PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BOILDII				С
		345191	B. WING _			03/	27/2024
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				542	2 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW		MC	DUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
E 000	Initial Comments		E	000			
E 039 SS=F	complaint investigation onsite 3/17/2024 thro information was obtain through 3/27/2024. The facility the requirement at CFP reparedness. Even EP Testing Requirem CFR(s): 483.73(d)(2) \$416.54(d)(2), \$482.7 \$460.84(d)(2), \$482.7 \$483.475(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.542(d)(2), \$485.920(d)(2), \$491 *[For ASCs at \$416.5 at \$485.542, OPO, "C \$485.727, CMHCs at \$491.12, and ESRD If (2) Testing. The [facility to test the emergency must do all of the following the fo	a recertification survey and on. The survey team was ugh 3/22/2024. Additional ined offsite on 3/18/2024. Therefore, the exit date was y was not in compliance with FR 483.73, Emergency t ID # HN5911. ents 113(d)(2), §441.184(d)(2), 15(d)(2), §483.73(d)(2), .102(d)(2), §485.68(d)(2), .625(d)(2), §485.727(d)(2), .12(d)(2), §494.62(d)(2). 4, CORFs at §485.68, REHs Organizations" under §485.920, RHCs/FQHCs at Facilities at §494.62]: ity] must conduct exercises y plan annually. The [facility] owing: -scale exercise that is ery 2 years; or ity-based exercise is not a facility-based functional	E	039			4/24/24
	natural or man-made activation of the emerexempt from engagin	experiences an actual emergency that requires rgency plan, the [facility] is g in its next required individual, facility-based					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

04/18/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024		
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		33/21/2024		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
E 039	actual event. (ii) Conduct an additivears, opposite the yfunctional exercise upont this section is conduct not limited to the following the f	onal exercise at least every 2 ear the full-scale or inder paragraph (d)(2)(i) of cted, that may include, but is owing: le exercise that is individual, facility-based or drill; or se or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions e an emergency plan. ity's] response to and cion of all drills, tabletop gency events, and revise the e plan, as needed. 8.113(d):] ces that provide care in the hospice must conduct emergency plan at least be must do the following: ll-scale exercise that is ery 2 years; or ity based exercise is not can individual facility based very 2 years; or overiences a natural or cy that requires activation of the hospital is exempt from required full scale	EO	39				

. ,		IDENTIFICATION AN IMPED		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345191	B. WING			C 03/27/2024		
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	<u> </u>	03/2//2024		
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
E 039	onset of the emerger (ii) Conduct an addit opposite the year the exercise under paragis conducted, that may to the following: (A) A second full-sca community-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator and incluse a narrated, clinically-scenario, and a set of directed messages, of designed to challeng (3) Testing for hospic care directly. The hospice may be exercised to test the year. The hospice may be exercised function (B) If the hospice expending the emergency plan, engaging in its next may be seed or facility-based following the onset of (ii) Conduct an addit may include, but is next of (A) A second full-sca	ncy event. icional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited ale exercise that is a facility based functional drill; or ise or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions e an emergency plan. These that provide inpatient espice must conduct emergency plan twice per nust do the following: annual full-scale exercise that or ity-based exercise is not an annual individual nal exercise; or prepared full-scale community end functional exercise for the emergency event. It is emergency event. It is a facility based functional	EC					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C 03/27/2024	
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIF 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		03/2//2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
E 039	(C) A tabletop exerci facilitator that include narrated, clinically-rel and a set of problem messages, or prepare challenge an emerge (iii) Analyze the hosp maintain documentati exercises, and emerge hospice's emergency *[For PRFTs at §441. §482.15(d), CAHs at (2) Testing. The [PRT conduct exercises to twice per year. The [do the following: (i) Participate in an a is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the [PRTF, Hospitation of [facility] is exempt fro required full-scale confacility-based function onset of the emergen (ii) Conduct an [and that may include, following: (A) A second full-scale community-based or functional exercise; o (B) A mock of the model of the community-based or functional exercise; o (B) A mock of the emergen (B) A mock of the emergen (B) A mock of (B) A mo	se or workshop led by a se a group discussion using a evant emergency scenario, statements, directed ed questions designed to ncy plan. sice's response to and on of all drills, tabletop lency events and revise the plan, as needed. 184(d), Hospitals at §485.625(d):] F, Hospital, CAH] must test the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or ty-based exercise is not an annual individual, hal exercise; or pital, CAH] experiences an emergency that the emergency plan, the mengaging in its next mmunity based or individual, hal exercise following the cy event. additional] annual exercise or but is not limited to the le exercise that is individual, a facility-based	E	039			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345191	B. WING _				27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		LL ROAD	1 03/	21/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	EFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE	
E 039	Continued From pag	e 4	E	39				
	led by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the maintain documentate exercises, and emergency *[For PACE at §460.4 (2) Testing. The PACE exercises to test the annually. The PACE following: (i) Participate in an assist community-based; (A) When a communaccessible, conduct a facility-based function (B) If the PACE experimental emergency plan, engaging in its next rebased or individual, fexercise following the event. (ii) Conduct an ayears opposite the years opposite the years opposite the years opposite the total community-based or functional exercise; (B) A mock disaster (B) A mock disaster	d includes a group parrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency [facility's] response to and cion of all drills, tabletop gency events and revise the o plan, as needed. [64(d):] E organization must conduct emergency plan at least organization must do the ennual full-scale exercise that or ity-based exercise is not an annual individual, hal exercise; or riences an actual natural or cy that requires activation of the PACE is exempt from equired full-scale community acility-based functional e onset of the emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section y include, but is not limited to alle exercise that is individual, a facility based or						

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	'	<u> </u>	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	using a narrated, cli scenario, and a set directed messages, designed to challeng (iii) Analyze the PA maintain documenta exercises, and eme PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based function (B) If the [LTC facility actual natural or ma requires activation of LTC facility is exemple required a full-scale individual, facility-based following the onset (ii) Conduct an add may include, but is in (A) A second full-scale individual exercise; (B) A mock disaster (C) A tabletop exercise a facilitator includes narrated, clinically-real and the second full-scale (C) A tabletop exercise (aides a group discussion, nically-relevant emergency of problem statements, or prepared questions ge an emergency plan. CE's response to and ation of all drills, tabletop regency events and revise the plan, as needed. at §483.73(d):] must conduct exercises to plan at least twice per year, ced staff drills using the res. The [LTC facility, e following: annual full-scale exercise that an annual individual, onal exercise. y] facility experiences an n-made emergency that of the emergency plan, the out from engaging its next community-based or used functional exercise that into limited to the following: cale exercise that is r an individual, facility based or	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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E 039	messages, or prepare challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §483 (2) Testing. The ICF/IID to test the emergency The ICF/IID must do (i) Participate in an an is community-based; (A) When a community accessible, conduct a facility-based function (B) If the ICF/IID experimental exercise for emergency event. (ii) Conduct an additional exercise for emergency event. (iii) Conduct an additional exercise for emergency event. (iii) Conduct an additional exercise for emergency event. (iii) Conduct an additional exercise; (C) A tabletop exercise a facilitator and including a narrated, clinis scenario, and a set of directed messages, of designed to challenge (iii) Analyze the ICF/I maintain documentated.	ed questions designed to ney plan. If acility] facility's response to entation of all drills, tabletop gency events, and revise the emergency plan, as needed. 3.475(d)]: ID must conduct exercises of plan at least twice per year. The following: In unal full-scale exercise that for the ICF/IID is exempt from the ICF/IID is exempt from the equired full-scale individual, facility-based llowing the onset of the ICF/IID is exempt from the equired full-scale individual, facility-based llowing the onset of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise that is an individual, facility-based or limited to the following: In a second of the ICF/IID is exempt from the exercise is not the exercise in the exercise is not the exercise that is a second of the ICF/IID is exempt from the exercise is not the exercise is	EC			

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E 039	to test the emergen- least annually. The (i) Participate in a fucommunity-based; of (A) When a cor accessible, conduct facility-based function. (B) If the HHA or man-made emergency plengaging in its next community-based of functional exercise emergency event. (ii) Conduct an addi opposite the year the exercise under para is conducted, the limited to the followin (A) A second fucommunity-based of functional exercise; (B) A mock disa (C) A tabletop of led by a facilitator and discussion, using a emergency scenario statements, directed questions designed plan. (iii) Analyze the HHA documentation of all	y plan, as needed. 102] HHA must conduct exercises cy plan at HHA must do the following: Ill-scale exercise that is or nmunity-based exercise is not an annual individual, onal exercise every 2 years; experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale r individual, facility based following the onset of the tional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section hat may include, but is not ng: ill-scale exercise that is r an individual, facility-based or exercise or workshop that is	EC					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345191	B. WING		C 03/27/2024		
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	33,21,232		
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLETION		
E 039	to test the emergency following: (i) Conduct a paperworkshop at least are led by a facilitator are discussion, using a remergency scenario statements, directed questions designed plan. If the OPO expended emergency plan, engaging in its next following the onset of (ii) Analyze the OPO documentation of all emergency events, a OPO's] emergency plan. *[RNCHIs at §403.7 (d)(2) Testing. The Fexercises to test the must do the following (i) Conduct a paperleast annually. A tab discussion led by a folinically-relevant en of problem statemer prepared questions emergency plan. (ii) Analyze the RNH maintain documental	aneeded. 360] DPO must conduct exercises by plan. The OPO must do the based, tabletop exercise or inually. A tabletop exercise is ad includes a group harrated, clinically relevant, and a set of problem messages, or prepared to challenge an emergency eriences an actual natural or cy that requires activation of the OPO is exempt from required testing exercise of the emergency event. It's response to and maintain tabletop exercises, and and revise the [RNHCI's and blan, as needed. 48]: RNHCI must conduct emergency plan. The RNHCI go based, tabletop exercise at letop exercise is a group facilitator, using a narrated, hergency scenario, and a set lets, directed messages, or designed to challenge an CI's response to and tion of all tabletop exercises, ints, and revise the RNHCI's	E 03	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				27/2024	
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E 039	by: Based on record rev facility failed to partic annually as part of the Preparedness (EP) p The findings included A review of the facility facility had no eviden exercise since March During an interview w 3/22/24 at 10:20 AM,	is not met as evidenced lew and staff interviews, the lipate in a tabletop exercise leir Emergency rogram. 's EP manual revealed the ce of conducting a tabletop 2022. With the Administrator on she indicated she was no tabletop exercise was	E	039	1. Corrective Action will be accomplished by the facility participatin in a tabletop exercise annually as part the facility Emergency Preparedness (I Program. The administrator has a scheduled tabletop exercise on 4/22/2024. 2. All residents have the potential to affected by this practice should an emergency occur. 3. Measures put into place to ensure that the deficient practice does not rect is the Administrator and Maintenance Director will ensure that exercises are conducted to test the emergency plan twice per year by participating in a full-scale exercise that is community based or conduct an annual individual facility-based exercise and completing facility tabletop exercise. The Administrator and Maintenance Director will in-service staff regarding the full scale/tabletop. 4. The facility will monitor its performance by the Maintenance Director maintaining documentation of all emergency events/tabletop exercises a will update the facility's emergency plan as needed. The Maintenance Director meet monthly with the Administrator to discuss the facility emergency events a scheduled tabletop with updates and recommendations from participation. T	of EP) be ur and n will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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E 039	results of the monthly monitoring w discussed in QAPI for the next 3 m		E 03	results of the monthly monitor			
F 000			a 3 monuis.				
	complaint investigationsite 3/17/2024 throinformation was obtain through 3/27/2024. To 3/27/2027. Event ID The following intakes NC00214618, NC002 NC00204574, NC002 NC00215063, and NC complaint allegations Intake NC00211094, NC00214618 resulted Immediate Jeopardy CFR 483.10 at tag F(K); the IJ began 11/3 3/23/24 CFR 483.12 at tag F6 (J); the IJ began 3/10 3/22/24 CFR 483.12 at tag F6 (J); the IJ began 3/10 3/22/24	a recertification survey and on. The survey team was ugh 3/22/2024. Additional ined offsite on 3/18/2024. Therefore, the exit date was HN5911. were investigated 210377, NC00211094, 213393, NC00200986, 200241958. 18 of the 26 resulted in deficiency. NC00210377, and d in immediate jeopardy. was identified at: 585 at a scope and severity 30/23 and was removed 602 at a scope and severity 30/23 and was removed 603 at a scope and severity 30/24 and was removed					
		/24 and was removed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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		345191	B. WING _			03/	27/2024
	ROVIDER OR SUPPLIER OMMUNITY HEALTH CE	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 000 F 550 SS=G	(K); the IJ began 3/1 3/22/24 CFR 483.25 at tag F (K); the IJ began 1/5 3/23/24 CFR 483.45 at tag F (K); the IJ began 10/3/23/24 CFR 483.80 at tag F (K); the IJ began 3/1 3/20/24 The tags F602, F603 constituted Substance An extended survey Resident Rights/Exe CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a riself-determination, a access to persons aroutside the facility, in this section.	607 at a scope and severity 0/24 and was removed 697 at a scope and severity /2024 and was removed 755 at a scope and severity /23/23 and was removed 880 at a scope and severity 8/24 and was removed 8, F604, F607, and F697 dard Quality of Care. was conducted. crcise of Rights (2)(b)(1)(2) Rights. ight to a dignified existence, and communication with and and services inside and ancluding those specified in ity must treat each resident		550			4/24/24
	with respect and digr resident in a manner promotes maintenan	nity and care for each and in an environment that ace or enhancement of his or cognizing each resident's illity must protect and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	<u> </u>	03/2//2024
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F 550	access to quality caseverity of condition must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The foresident can exercise interference, coercifrom the facility. §483.10(b)(2) The foresident can exercise of interference, reprisal from the facility. §483.10(b)(2) The foresident can exercise of his or he subpart. This REQUIREMENT by: Based on record reand staff interviews residents' dignity whim feces and saturar reviewed for dignity Resident #305). Whimcontinent care Resumborthy of being legionered, uncomfortation.	acility must provide equal are regardless of diagnosis, a, or payment source. A facility maintain identical policies and transfer, discharge, and the sunder the State plan for all sof payment source. The of Rights. The right to exercise his or her of the facility and as a citizen inited States. The control of the right without conductive in the serior of the facility and as a citizen inited States. The control of the right without conductive in the right to be coercion, discrimination, or reprisal in the ser rights as required under this in the properties as required under this in the facility failed to protect the residents were left soiled at the right and the right to provided sident #4 reported feeling tooked at, sanitary rights being able, and nasty; Resident	F 5	1. Immediate action(s) taken resident(s) found to have been include: " Resident #4 on 3/17/24 at received incontinence care per resident. Resident #305 on 3/1 approximately 330pm had rece incontinence care and was clear per the resident. 2. Identification of other resid the potential to be affected was accomplished by:	affected 2pm the 17/24 at ived an and dry ents having	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C 27/2024
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112024
				5	542 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		ľ	MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 13	F 5	550			
	6/22/23 with diagnose				" The facility determined that all		
		scular dysfunction of the			incontinent residents have potential to	be	
	bladder, and the need personal care.				affected.		
	•				3. Actions taken/systems put into pla	.ce	
	The Minimum Data S	Set (MDS) quarterly			to reduce the risk of future occurrence		
	assessment dated 01			include:			
	was cognitively intact			" The VP of Clinical, Regional Nurse	∍,		
		lling catheter, and required			Administrator, Director of Nursing,		
		assistance by staff with			Assistant DON, and/or Unit manager w		
		MDS indicated her vision			provide education beginning 4/18/2024		
	was adequate. She h	ad no rejection of care.			all staff on the Quality of Life-Dignity po	olicy	
	An interview and obs	ervation were performed on			and the importance of ensuring that Dignity is maintained with regards to		
		with Resident #4. She stated			timely incontinence care.		
	.,	tinence and had turned on			" All new Staff will be in serviced on		
		assistance 30 minutes prior			these items and policies during the		
	_	She had a clock located on			orientation process by the DON or ADO	ON.	
		Her call light was observed			" Any Staff who have not went throu		
		Il light visible above her door			the training prior to the compliance dat	•	
	from the hall.				will have to do so prior to working agai " Any Agency staff will be educated	n.	
	At 11:36 AM Nurse A	ide #3 (NA) entered			prior to working.		
		turned off the call light, and					
					4. How the corrective action(s) will be	Э	
	On 3/17/24 at 12:23 I	PM Resident #4's lunch meal			monitored to ensure the practice will no		
	tray was observed be	eing delivered by the			recur:		
	Admission Coordinate	or.			" The VP of Clinical, Regional Nurse	∍,	
					ADON and/or Unit Manager will comple		
		formed with the Admission			an audit of 3 random residents per hall		
		pm on 3/17/24 upon her			beginning 4/18/2024, 5 times per wee		
exiting the room. The Admission Coordinator 4 weeks then 3 x per week x 8 weeks to		.0					
	explained her role at				ensure that incontinence care is being		
		or. She stated she had			provided timely.		
		al tray for Resident #4. She			" Any deficient practice found during		
		l asked her for ice and to			the audits will be corrected immediately	•	
	· ·	en. She did not mention a lent needed assistance with			and education and/or corrective action done by the DON as appropriate.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			l	27/ 2024
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112024
				542	ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CEN	ITER BY HARBORVIEW		MC	OUNT AIRY, NC 27030		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	and observation was She was observed in bed raised, with her in her on the overbed ta provided incontinent of incontinent bowel more NA #3 had told her "Sto her as soon after lu #4 verbalized eating hincontinent bowel more and uncomfortable". Sumworthy", and no or look at her. A follow up interview or Resident #4 on 3/17/2 she was clean and dructo provide her bowel in PM. She stated she ke because a family merher hair. She stated in PM made her feel "lest else and like my saniting incred". An interview was perful PM with MA #4. She she checked every two hoshe explained If a reshad requested to be on have to wait. MA #4 shave to sit in bowel mone should have to sit that was "disgusting." degrading for a reside the state of	PM an additional interview performed with Resident #4. bed, with the head of her heal tray set up in front of ble. She stated staff had not care and she still had wement in place. She stated he was sorry and would get inch as she could" Resident her meal while sitting in wement made her feel "nasty She said this made her feel he was taking the time to was performed with 24 at 3:41 PM. She stated by She said NA #3 had come incontinence care at 2:00 new the time was 2:00 PM inber was at the facility doing ot being changed until 2:00 is important than everyone	F 5		" The Audit findings will be reported the DON in a Monthly QAPI meeting for minimum of 3 months. 5. The Administrator is responsible for thee execution of this plan with a compliance date of 4/24/2024.	ra	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345191	B. WING		03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 550	PM with NA #3. NA able to make it thre hall (B hall) for residunch trays had contypically only able to care during her 7:00 stated she did not guntil 2:00 PM. She incontinence when for her. NA #3 explain on her call bell before incontinence care a before lunch. NA #3 call light before lunch would be back but thought having to e would make her and An interview with the was performed on a stated staff should soon as possible. Sincontinent care at resident. She explain heavier and needed frequently. She staff try to make rocevery 2-3 hours. Shif staff could get to its st	#3 stated she had only been e-fourths of the way down her dent care and rounds before ne out. NA #3 stated she was to do 3 rounds for incontinence DAM-7:00PM shift. NA #3 go in to change Resident #4 stated Resident #4 had bowel she provided incontinent care ained Resident #4 had turned	F 55	,		
	not turn off a call lig incontinent care. She attended to and explained staff coul care even if meal so said if no one was a go in the room and	the if the resident had called for the stated the call bell should should not be passed. She diprovide bowel incontinence the partial of the provide bowel incontinence to being in control of yourself				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024	
	ROVIDER OR SUPPLIER	CENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR 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 550	performed with the Administrator state provide incontinent requested to. She scare to be provided Administrator explainment of the Administrator explainment of the Administrator state, and stated should be administrator of the Administrator of the Administrator of the Administrator of the Administrator of a meal in bowel incresident not feel golike it and was not happened. 2.) Resident #305 of 3/6/24 with diagnost weakness, and the personal care. The Minimum Data assessment dated #305 had moderate incontinence of both substantial maximum toileting hygiene. So On 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene. So on 3/17/24 at 11:3 interview were performed to the substantial maximum toileting hygiene.	PM an interview was Administrator. The d she expected the staff to be care when they were said she expected incontinent d in a timely manner. The sained timely as being within d she would expect staff to sted residents frequently to for incontinent care needs. So and on what frequently meant, stated she could not expand on the could not say every 2 hours. Stated a resident having to eat continence would make the sood. She said they would not something that should have was admitted to the facility on sees including muscle need for assistance with I Set (MDS) admission 3/12/24 revealed Resident ely impaired cognition. She had well bladder and required um assistance by staff with the had no rejection of care.	F 5	50			
	She was observed on. She was laying her body slid down						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		33/21/2024	
(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 COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	visible wetness und blanket was wet to the stated she was "wet to the stated she was "wet to the stated she was "wet to the stated she was personal to the stated she gave Resonat mention any odd care needs for the recovered her with the stated she gave Resonat mention any odd care needs for the recovered her with the stated she gave Resonat mention any odd care needs for the recovered her with the stated she gave Resonat mention any odd care needs for the recovered she was observed and the state of the bed raised of the bed raised of the bed raised of the bed raised of the overbed she was still wet. She was going to conshe was unable to she was unable	#305's bottom sheet had a er her buttock and her top he touch. Resident #305". PM NA #3 and the Assistant ADON) were observed ent #305 up in her bed and her blankets. If or med at 12:31pm on DON exited the room, she sident #305 insulin. She did or of incontinence or other esident. PM the Admission served entering the room with bed the tray on Resident e. NA #3 was still at the #305 and provided meal tray If and observation was ear and observation was er well at 12:32 PM with Resident erved in her bed, with the ed, in her gown, holding a er meal tray set up in front of table. Resident #305 stated he stated, "that woman said me change me in a little bit". ay who "that woman" was. not being changed prior to feel "wet and cold" and said,	F 5	50			
	#305 was performed	d on 3/17/24 at 3:39 PM. She her wheelchair, with a new					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345191	B. WING		C 03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/21/2024	
				542 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 550	Continued From page	e 18	F 55	50		
	gown, her bed was m	ade with new linen and a ident #305 stated she was				
	PM with MA #4. She checked every two homeeds. She explained incontinent and had residents should not have residents should not leat. She verbalized it resident to have to sit their meal. An interview was performed in the performance in the performance in the performed in the performance	equested to be changed, to wait. MA #4 said have to sit in incontinence to would be degrading for a tin a wet soiled brief to eat formed on 03/17/24 at 4:45 as stated she had only been fourths of the way down her not care and rounds before. NA #3 stated she was do 3 rounds for incontinence time. NA #3 seen able to provide care to 1:00 PM. She said when she 10.5 at 2:00 PM she was "very resident #305's sheets and and she had to change to bed. She explained, when the 1:00 PM she was "very the sident was wet. NA #3 said she while sitting in incontinence the resident feel terrible. Director of Nursing (DON) 21/24 at 4:15 PM. The DON to 1:00 PM she was requested the residents urinated the residents urinated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C 27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CE	NTER BY HARBORVIEW	•	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE		(X5) COMPLETION DATE
F 550	staff try to make roune every 2-3 hours. She if staff could get to it what staffing was like. On 3/21/24 at 4:40 P performed with the Administrator stated provide incontinence requested to. She sa care to be provided in Administrator explain 10-15 min. She said check on non-oriente throughout the shift for When asked to expant the Administrator staft that, and stated she of Self-Determination CFR(s): 483.10(f)(1)-\$483.10(f) Self-determination CFR(s): 483.10(f)(1) The resident has the promote and facilitate through support of renot limited to the righ (1) through (11) of this \$483.10(f)(1) The resident provisions waking times), health care services consist assessments, and pla applicable provisions	d for non-oriented residents, ds for incontinence care explained she was not sure at that frequency because of st. M an interview was dministrator. The she expected the staff to care when they were id she expected incontinent in a timely manner. The ed timely as being within she would expect staff to d residents frequently for incontinent care needs. Ind on what frequently meant, and on what frequently meant, and on what frequently meant, and on the say every 2 hours. (3)(8) mination. right to and the facility must be resident self-determination is sident choice, including but the specified in paragraphs (f) is section. Sident has a right to choose (including sleeping and care and providers of health ent with his or her interests, an of care and other		561			4/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE,	•	00/21/2024	
				542 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH C	ENTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 561	Continued From pa	ge 20	F 5	661			
	facility that are sign	ificant to the resident.					
	with members of th	esident has a right to interact e community and participate in s both inside and outside the					
	participate in other religious, and comr interfere with the rig facility. This REQUIREMED by:	esident has a right to activities, including social, nunity activities that do not ghts of other residents in the NT is not met as evidenced					
	and record review, resident's preference			Immediate action(seesident(s)) found to hat include: The facility failed the preference for showers residents. Resident # 2 resides in the facility. For offered a shower by the seesident in the facility.	ve been affected o honor residents□ s for 2 of 4 256 no longer Resident # 59 was		
	chronic obstructive atrial fibrillation, an personal care.	s admitted on 11/8/23 with pulmonary disease, diabetes, d a need for of assistance with		on 3/21/24 and he refu 2. Identification of oth the potential to be affect accomplished by: " All residents have	sed. her residents having cted was the potential to be		
	needing assistance personal hygiene re impairments. Revie plan did not include refusals of assistan Review of Residen Interview for Daily a assessment dated	care planned on 11/17/23 for with grooming, bathing and elated to mobility and self-care ew of the comprehensive care a problem area for any ace with his ADLs. t #59's admission Activity and Activity Preferences 11/16/24 read choosing and shower was very		affected by this deficien 3. Actions taken/syst to reduce the risk of fut include: " The Social service 4/17/24 will interview or with a BIMS above 8 to preference regarding s " Director of Nursing VP of Clinical, Regional Manager will educate a shower schedule and p	tems put into place ture occurrence es Director, starting urrent residents o determine their howers. g, Assistant DON, al Nurse and/or Unit all nursing staff on		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C 27/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112024
					42 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW			MOUNT AIRY, NC 27030		
	OUR MARRY OF	ATTENTION OF DEFINITION					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From page	e 21	F t	561	make sure they complete refusal		
	The guarterly Minimu	m Data Set dated 2/14/24			documentation.		
		59 was cognitively intact,			" All new Nursing Staff will be in		
		rs and required partial to			serviced on these items and policies		
		with bathing and showering.			during the orientation process by the D or ADON.	ON	
	An observation was o	completed on 3/21/24 at 9:40			" Any Nursing Staff who have not w	ent	
	AM. Resident #59 was lying on top of his bed				through the training prior to the		
	wearing a button up shirt and a pair of shorts. He				compliance date will have to do so price	r to	
	appeared disheveled	but he was absent of bodily			working again.		
	odors.	•			" Any Agency staff will be educated		
					prior to working.		
	During an interview w	vith Resident #59 on 3/21/24					
		I he completed his own			4. How the corrective action(s) will be	Э	
	baths. He stated on c	occasion, one of the aides			monitored to ensure the practice will no		
	would come in and se	et his bath items up but on			recur:		
	most occasion, they	did not. Resident #59 stated			" The Director of Nursing (DON),		
	staff were not providi	ng him any showers and had			ADON and/or Regional Nurse will cond	luct	
		ited he really needed and			5 random audits weekly x 8 weeks to		
	wanted regular show	ers. Resident #59 stated he			ensure Shower preferences are being		
	had not mentioned it	to anyone because he liked			honored and refusals are documented		
	it at the facility and he	e did not want to get "kicked			" Any deficient practice found during	j	
	out".				the audits will be corrected immediately	y	
					and education and/or corrective action		
	Review of Resident #	59 electronic medical record			done by the DON as appropriate.		
	did not include any do	ocumented evidence of a			" The Audit findings will be reported	by	
	shower from 1/1/24 to	o 3/21/24. The facility also			the DON in a Monthly QAPI meeting for	r a	
	did not provide any o	ther form of documentation			minimum of 3 months.		
	indicating Resident #	59 had received a shower					
	from 1/1/24 to 3/21/24	4.					
	A	onlated on 2/24/24 -+ 0:40					
		npleted on 3/21/24 at 2:40					
		stant (NA) #5. She stated					
	,	with Resident #59 and knew					
		er per his request but was					
	unable to state where						
		tated Resident #59 does not					
	refuse any ADLs and						
	concerns that would	prevent her from completing					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			(X3) DATE SURVEY COMPLETED	
	345191	B. WING _			C 03/27/2024	
ROVIDER OR SUPPLIER DMMUNITY HEALTH CE	NTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		ZIP CODE	03/2//2024	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVI CROSS-REFERENCED	E ACTION SHOULD BE O TO THE APPROPRIA		
her assignments. An interview was cor PM with NA #6. She not go to the shower because he had a prilegs and it was not sany staffing concerns assisting Resident #8. A wound care observable observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was pasms were observable of the showing any problem was staff took and wanted a desire for regular shows the Regional Corpora statement. During an interview was 3/22/24 at 10:20 AM, explanation as to what receiving his scheduled and/or 2. Resident #256 was facility on 06/15/23 was facility o	Inpleted on 3/21/24 at 2:45 stated Resident #59 could room because it wasn't safe oblem with spasms in his afe for him. NA #6 denied is that would prevent her from 59 with showers. Interest a state of the state o	F	561			
,						
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page her assignments. An interview was con PM with NA #6. She not go to the shower because he had a pre legs and it was not so any staffing concerns assisting Resident #8 A wound care observe 3/22/24 at 10:10 AM and the Regional Con Treatment Nurse and having any problem of spasms were observe his left foot. Resident come in to help him of thought the last time two months ago. Resident come in to help him. Neithe two months ago. Resident come in to help him. Neithe Regional Corpora staff to help him. Neithe Regional Corpora staff to help him. Neithe Regional Corpora staff to help him. Staff to help him. Neithe the Regional Corpora statement. During an interview of 3/22/24 at 10:20 AM, explanation as to why receiving his schedul her expectation that if as scheduled and/or 2. Resident #256 was facility on 06/15/23 why hypertension and mut-	An interview was completed on 3/21/24 at 2:45 PM with NA #6. She stated Resident #59 could not go to the shower room because it wasn't safe because he had a problem with spasms in his legs and it was not safe for him. NA #6 denied any staffing concerns that would prevent her from assisting Resident #59 with showers. A wound care observation was completed on 3/22/24 at 10:10 AM with the Treatment Nurse and the Regional Corporate Nurse present. The Treatment Nurse and Resident #59 stated he had come in to help him with a bath yet and he thought the last time he had a shower was maybe two months ago. Resident #59 stated he needed staff to help him. Neither the Treatment Nurse or the Regional Corporate Nurse acknowledged her	A BUILDING ROVIDER OR SUPPLIER DMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 her assignments. An interview was completed on 3/21/24 at 2:45 PM with NA #6. She stated Resident #59 could not go to the shower room because it wasn't safe because he had a problem with spasms in his legs and it was not safe for him. NA #6 denied any staffing concerns that would prevent her from assisting Resident #59 with showers. A wound care observation was completed on 3/22/24 at 10:10 AM with the Treatment Nurse and the Regional Corporate Nurse present. The Treatment Nurse and Resident #59 denied him having any problem with leg spasms and no leg spasms were observed during the wound care to his left foot. Resident #59 stated no staff had come in to help him with a bath yet and he thought the last time he had a shower was maybe two months ago. Resident #59 stated he really needed and wanted a shower. He confirmed his desire for regular showers but stated he needed staff to help him. Neither the Treatment Nurse or the Regional Corporate Nurse acknowledged her statement. During an interview with the Administrator on 3/22/24 at 10:20 AM, she was unable to offer any explanation as to why Resident #59 was not receiving his scheduled showers but stated it was her expectation that his showers were completed as scheduled and/or requested. 2. Resident #256 was originally admitted to the facility on 06/15/23 with diagnoses which included hypertension and muscle weakness.	ROMDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 22 her assignments. An interview was completed on 3/21/24 at 2:45 PM with NA #6. She stated Resident #59 could not go to the shower room because it wasn't safe because he had a problem with spasms in his legs and it was not safe for him. NA #6 denied any staffing concerns that would prevent her from assisting Resident #59 stated no staff had come in to help him with a bath yet and he thought the last time he had a shower. He confirmed his desire for regular showers but stated he needed staff to help him. Neither the Treatment Nurse or the Regional Corporate Nurse acknowledged her statement. During an interview with the Administrator on 3/22/24 at 10:20 AM, she was unable to offer any explanation as to why Resident #59 was not receiving his scheduled showers but stated it was her expectation that his showers were completed as scheduled and/or requested. 2. Resident #256 was originally admitted to the facility on 06/15/23 with diagnoses which included hypertension and muscle weakness.	A BUILDING 345191 BY WING STREETADDRESS, CITY, STATE, ZIP CODE 542 ALIRED MILL ROAD MOUNT AIRY, NC. 27030 SUMMARY STATEMENT OF DEPOLENCIES (EACH DEPOCINCY) WIST ES PERCEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 An interview was completed on 3/21/24 at 2-45 PM with NA #6. She stated Resident #59 could not go to the shower room because it wasn't safe because he had a problem with spasms in his legs and it was not safe for him. NA #6 denied any staffing concerns that would prevent her from assisting Resident #59 with showers. A wound care observation was completed on 3/22/24 at 10-10 AM with the Treatment Nurse and the Regional Corporate Nurse present. The Treatment Nurse and Resident #59 stated no staff had come in to help him with a bath yet and he thought the last time he had a shower was maybe two months ago. Resident #59 stated he needed staff to help him. Neither the Treatment Nurse or the Regional Corporate Nurse acknowledged her statement. During an interview with the Administrator on 3/22/24 at 10-20 AM, she was unable to offer any explanation as to why Resident #59 was not receiving his scheduled showers but stated it was her expectation that his showers were completed as scheduled and/or requested. 2. Resident #256 was originally admitted to the facility on 06/15/23 with diagnoses which included hypertension and muscle weakness.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345191	B. WING _		 	C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		, 00:2:::20	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 561	assistance with gro hygiene due to mot motion limitations re weakness. The goal improve the current by next review. Review of the Resid Data Set (MDS) davery important to chance shower, bed bath, or Review of Resident Data Set (MDS) daversident was moder required physical healthing. The MDS fewere coded for Resident was documentation from revealed it was documented it	he resident required coming, bathing, and personal collity impairment, range of celated to generalized all was for Resident #256 to be level of physical functioning dent 256's admission Minimum atted 06/22/23 revealed it was coose between a tub bath, or sponge bath. #256's quarterly Minimum atted 11/28/23 revealed the crately cognitively impaired and celp with one person assist for further revealed no refusals cident #256. #256's shower and 12/01/23 through 02/01/24 umented the resident had an on 12/14/23, 12/18/23, and cocheduled bathing days. Cotted with Resident #256's attative (RR) on 03/06/24 at they had visited the resident R further revealed there had Resident #256 had received a preferred shower due to dicated nursing staff had	F5	661		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	· /	TE SURVEY MPLETED
		345191	B. WING		م ا	C 3/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		5/2//2024
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 561 F 585 SS=K	baths due to short st pulled to the floor to for other residents. An interview conduct 12:25 PM revealed to thad not received a p staffing concerns. No bath was often given because staff would to conduct incontiner and assist on other had expected reside bath or shower. It had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected reside bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected bath or shower. The unaware staff were had expected reside bath or shower. It had expected by the had expected by the had ex	at had received multiple bed affing and NAs had to be conduct incontinence care sed with NA #8 on 03/26/24 at here was issues residents referred shower due to A #8 further revealed a bed instead of a shower have to be pulled to the floor nee care for other residents halls. sed with the Director of he Administrator on 03/26/24 they did not recall Resident ed baths instead of a was further revealed they not receive their preferred by indicated they were having difficulty performing ed.	F 5			4/24/24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024		
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	'	OOI ETT EULT		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 585	§483.10(j)(2) The refacility must make presolve grievances accordance with thi §483.10(j)(3) The factor on how to file a grie to the resident. §483.10(j)(4) The factor of all grievance policy to of all grievances recontained in this paperovider must give to the resident. The include: (i) Notifying resident postings in promine facility of the right to (meaning spoken) of grievances anonymof the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revisto obtain a written of grievance; and the independent entitie be filed, that is, the Quality Improveme Agency and State L program or protecti (ii) Identifying a Griresponsible for overeceiving and track conclusions; leadin	esident has the right to and the prompt efforts by the facility to the resident may have, in	F 5	85				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		3312112024	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 585	example, the identity grievances submitted written grievance decoordinating with stanecessary in light of (iii) As necessary, taprevent further poterright while the allege investigated; (iv) Consistent with § reporting all alleged abuse, including injuicand/or misappropriation anyone furnishing seprovider, to the admit as required by State (v) Ensuring that all vinclude the date the summary statement the steps taken to insummary of the pertiregarding the resident as to whether the griconfirmed, any correctaken by the facility and the date the writh (vi) Taking appropriation accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or location frights within its area (vii) Maintaining evid result of all grievance	ed with grievances, for of the resident for those d anonymously, issuing cisions to the resident; and the and federal agencies as specific allegations; king immediate action to intial violations of any resident of violation is being season and the dividation involving neglect, ries of unknown source, the decision behalf of the inistrator of the provider; and law; written grievance decisions grievance was received, a of the resident's grievance, a ment findings or conclusions int's concerns(s), a statement evance was confirmed or not extive action taken or to be as a result of the grievance, then decision was issued; the corrective action in the law if the alleged violation is is confirmed by the facility of having jurisdiction, such as ency, Quality Improvement allaw enforcement agency for any of these residents'	F 5	85			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` '	(3) DATE SURVEY COMPLETED	
		345191	B. WING			1	07/0004	
NAME OF D	DOVIDED OD SUDDUED	040101	1		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2024	
NAME OF PI	ROVIDER OR SUPPLIER							
SURRY CO	OMMUNITY HEALTH CEN	NTER BY HARBORVIEW			12 ALLRED MILL ROAD			
				M	OUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 585	Continued From page decision.	e 27	F 5	85				
		is not met as evidenced						
	Based on record revi	iew and Resident, Resident			1. Immediate action(s) taken for the			
	Representative (RR)	and staff interviews the			resident(s) found to have been affected	Ł		
	facility failed to impler	ment grievance policy and			include:			
		esident (Resident #21)			" Resident #21 had a grievance			
		the facility was running out			completed on 3/22/24 by the Regional			
		ne Director of Nursing (DON)			Nurse related to her past complaints th	at		
		evance and on 12/01/23			the facility runs out of her Methadone			
		21 had Methadone in the			frequently. Resident stated that she ha			
		it had been documented as			not experienced the facility running out	of		
		ON did not interview the			Methadone since her complaint in			
		if there had been any			November. The resident states that sh	е		
		esident #21's Methadone.			is no longer in fear of not having her			
		estigation this problem			medication. Full Grievance completed			
	continued. Resident	awful pain of greater than ten			Identification of other residents hat the potential to be affected was	virig		
		Resident #21 stated she			accomplished by:			
		night and her anxiety was			" The facility has determined that all	1		
		she was afraid she would			residents have the potential to be			
		ions available and feeling as			affected.			
		ugh withdrawals. The deficit			Actions taken/systems put into pla	CE		
		1 of 1 resident (Resident			to reduce the risk of future occurrence			
	#21) reviewed for grie				include: " The facility□s policies and procedu	ıres		
	Immediate ieonardy h	pegan on 11/30/2023 when			on Resident and Family Grievances we			
		grievance and reported the			reviewed on 3/22/24 by the DON,	,,,		
		ut of her Methadone and a			Administrator/Grievance Official, Socia	1		
		n was not completed to			Worker, Assistant Director of Nursing			
		re issues with supply.			(ADON), Regional Nurse Consultant,			
		vas removed on 03/23/24 at			Regional Operations, and VP of Clinica	al.		
		cility implemented a credible			The VP of Clinical inserviced the	ĺ		
		te jeopardy removal. The			participants on the Resident and Famil	y		
	_	compliance at a lower			Grievances policy and the importance	•		
		vel "E" (no actual harm with			following through with the investigation			
		than minimal harm that is			all Grievances that are filed and tracking			
	· · · · · · · · · · · · · · · · · · ·	dy) to complete employee			the grievance through to the conclusion	-		
		monitoring systems put into			and providing written decision to the			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE S COMPL	
					С	
		345191	B. WING		03/2	7/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·	
				542 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH	CENTER BY HARBORVIEW		MOUNT AIRY, NC 27030		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION DATE
F 585	Continued From p	age 28	F 58	5		
	place are effective).		resident or responsible party by the	ne	
	•			Grievance Official.		
	The findings include	ded:		" The DON, ADON, Social Wo	rker	
				and/or Regional Nurse on 3/22/24	1 began	
		esident and Family Grievances		educating all staff on ensuring that		
		ed on 1/30/2023 stated 'the staff		grievances made are reported ac		
	_	the grievance will record the		to our Resident and Family Griev		
	•	cs of the grievance on the		policy and all will be educated pri		
		nce form or assist the resident		next shift. The DON, Social Work		
	· ·	to complete the form. Reports		ADON will be responsible for kee	. • .	
	injuries of unknow	involving neglect, abuse,		with who has and has not been in and completing the education the		
		of resident property immediately		or assigning the Administrator, Re		
		or and follow procedures for		Operations or VP of Clinical to as	-	
		The policy further states 'the		training as needed. All New Staff		
		, or designee, will keep the		agency staff will also be inservice		
		itely apprised of progress		orientation or before taking a resi	-	
	towards resolution	of the grievances and 'in		assignment.		
	accordance with the	ne resident's right to obtain a		" All staff inserviced again star	ting	
		garding his or her grievance,		4/18/24 by the DON, ADON, Soci		
		cial will issue a written decision		Worker, VP of Clinical, Administra		
	_	o the resident or representative		and/or Regional Nurse on ensurir	-	
		of the investigation. The written		grievances made are reported ac		
		de at a minimum: the date the		to our Resident and Family Griev	ances	
	_	eived, the steps taken to evance, a summary of the		policy. " All new Staff will be in service.	od on	
		or conclusions regarding the		these items and policies during the		
	·	i(s), a statement as to whether		orientation process by the DON of		
		confirmed or not confirmed,		" Any staff who has not went the		
		ion taken or to be taken by the		the training prior to the compliance	-	
	· -	of the grievance, and the date		will have to do so prior to working		
	the written decisio	_		" Any Agency staff will be educ		
				prior to working.		
		s admitted to the facility on		4. How the corrective action(s)		
		ignoses which included		monitored to ensure the practice	will not	
		cts the lower half of the body,		recur:		
		nereditary and idiopathic		" The Administrator and/or DO		
		e pain), major depressive		conduct a review of all Grievance	-	
	disorder, insomnia	a, headache, chronic pain		beginning 4/18/24 for four consec	cutive	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345191	B. WING _				C 27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CEI	NTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030	1 03/	2112024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 585	syndrome, and opioid A quarterly Minimum 11/20/2023 revealed cognitively intact. Review of a grievance by the Business Offic Resident #21 reporte of her Methadone. To documentation on the Methadone was on the been administered pe Director of Nursing (E on 12/1/2023. No fur of pertinent findings, written decision was in A quarterly Minimum 2/13/2024 revealed Fi intact. An interview was con 12:18 pm with Reside reported starting the was told by a night sh Aide (MA) #3, that the Methadone, the pharm of her pain medicatio would tell her that she medication and never frequently beginning Resident #21 reporte time without getting h 6:00 AM dose) and e terrible/awful pain gre to 10, and went throu	Data Set (MDS) dated Resident #21 was e dated 11/30/2023 received the Manager revealed d the facility was running out the handwritten the grievance form noted the medication cart and had ther documentation. The DON) signed the grievance ther investigation, summary conclusions or the date the ssued were documented. Data Set (MDS) dated the sident #21 was cognitively ducted on 3/18/2024 at tent #21. Resident #21 tend of November 2023 she ther investigation are facility had run out of her macy had not sent enough the at one time, or MA #3 the would bring her pain the return. This occurred more tin December of 2023 and d she went several days at a ter Methadone (9:00 PM and experienced severe anxiety, the staff than ten on a scale of 1 the date of 1	F	585	weeks then five grievances biweekly formonths. The review will ensure that all grievances were completed accurately and per the Grievance Policy. "Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the Administrator as appropria. "The Audit findings will be reported the Administrator in a Monthly QAPI meeting for a minimum of 3 months. 5. The Administrator is responsible for thee execution of this plan with a compliance date of 4/24/2024.	g y ite. by	
F 585	syndrome, and opioid A quarterly Minimum 11/20/2023 revealed cognitively intact. Review of a grievance by the Business Offic Resident #21 reporte of her Methadone. To documentation on the Methadone was on the been administered pe Director of Nursing (E on 12/1/2023. No fur of pertinent findings, written decision was in A quarterly Minimum 2/13/2024 revealed Fi intact. An interview was con 12:18 pm with Reside reported starting the was told by a night sh Aide (MA) #3, that the Methadone, the pharm of her pain medicatio would tell her that she medication and never frequently beginning Resident #21 reporte time without getting h 6:00 AM dose) and e terrible/awful pain gre to 10, and went throu	Data Set (MDS) dated Resident #21 was e dated 11/30/2023 received the Manager revealed d the facility was running out the handwritten the grievance form noted the medication cart and had ther documentation. The DON) signed the grievance ther investigation, summary conclusions or the date the ssued were documented. Data Set (MDS) dated the sident #21 was cognitively ducted on 3/18/2024 at tent #21. Resident #21 tend of November 2023 she ther initiation the facility had run out of her macy had not sent enough the at one time, or MA #3 the would bring her pain the return. This occurred more time December of 2023 and d she went several days at a ter Methadone (9:00 PM and experienced severe anxiety, the start of the service of 1 gh 'withdrawal symptoms' they, pain, nausea, and a	F	585	months. The review will ensure that all grievances were completed accurately and per the Grievance Policy. "Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the Administrator as appropria "The Audit findings will be reported the Administrator in a Monthly QAPI meeting for a minimum of 3 months. 5. The Administrator is responsible for thee execution of this plan with a	g y ite. by	

		(3) DATE SURVEY COMPLETED				
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	CODE	03/2//2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 585	85 Continued From page 30		F t	585		
	Methadone at the enthat no one had addiregarding her concerthe problem was one weeks ago. An interview was corpm with the DON. Trinvestigated Resider acknowledged that seed that the problem was cart and per docume Administration Record administered without reported that when a should be investigated.	facility running out of her d of November 2023 and ressed/spoke with her rns. Resident #21 reported going until about three or four adducted on 3/19/2024 at 3:16 he DON confirmed she had at #21's grievance and he did not go speak with the issue. She reported she poess because Resident as present on the medication and (MAR) it was initialed as a comissions. The DON a grievance was completed, it ed, and the resident or ve should be notified of the				
	reported most grieval nursing department. grievance is received investigate the issue RR of the outcome. Worker (SW) had the She reported grievar clinical meetings and discuss them in a stapertained to nursing. An interview was coupm with Resident #2 Resident Represents	was conducted on in with the DON. The DON inces were turned into the She reported when a di, administrative staff would inces, and notify the resident or She reported the Social engrievance log in her office. Inces were discussed in their different the Administrator would and-up meeting if they inducted on 3/20/2024 at 2:43 1's representative. The lative (RR) reported Resident y told on night shift that the				

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′			(X3) DATE SURVEY COMPLETED	
	345191	B. WING			C 3/27/2024	
	1		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	3/2//2024	
(EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
dethadone) and Recievance on 11/30/2 are middle of Februar it in the second state of the middle of Februar it in the second seco	f her pain medication esident #21 had filed a 2023. This continued through ary 2024. She reported the dent #21 the pharmacy had alled her daughter calling her to the night from December 2024 hysterical and she was worried, she was not dication. Inducted on 3/22/2024 at 8:52 the SW stated staff are trained ince form when a resident or sive (RR) voiced a concern, should then be given to a placed in an administrative rovided with a copy of the sted she logged the sured they were investigated they were investigated they were investigated after the grievance in the grievance would contact the resident at a grievances were usually burs. She had Resident #21's rm in the grievance log but all if Resident #21 or the RR the outcome. Inducted on 3/20/2024 at diministrator. The end she was not aware and a grievance on	F 58	35			
The second of th	SUMMARY S (EACH DEFICIENCE REGULATORY OR continued From page acility had run out of Methadone) and Resirevance on 11/30/2 ne middle of February is acility had told Resirevance in the second second to get her medical to ge	DRRECTION IDENTIFICATION NUMBER:	MUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Tontinued From page 31 F56 acidity had run out of her pain medication Methadone) and Resident #21 had filled a rievance on 11/30/2023. This continued through he middle of February 2024. She reported the acidity had told Resident #21 the pharmacy had of sent it. She recalled her daughter calling her multiple times during the night from December 023 until February 2024 hysterical and ightened because she was worried, she was not oing to get her medication. In interview was conducted on 3/22/2024 at 8:52 m with the SW. The SW stated staff are trained to complete a grievance form when a resident or seident representative (RR) voiced a concern. The grievance form should then be given to a epartment head or placed in an administrative nailbox. She was provided with a copy of the rievance and reported she logged the rievances and ensured they were investigated and resolved. The SW reported that new concerns were brought up in their morning clinical neeting. She reported after the grievance if ney were alert and oriented and if the grievance was filed by a RR, they would contact the resident being involved in the grievance if new were alert and oriented and if the grievance was filed by a RR, they would contact the resident mother of the RR. She stated grievances were usually andled within 24 hours. She had Resident #21's riginal grievance form in the grievance log but was not able to recall if Resident #21 or the RR ad been notified of the outcome. In interview was conducted on 3/20/2024 at 0:50 am with the Administrator. The dministrator reported that	A BUILDING 345191 A BUILDING A BUILDING B WINK STREET ADDRESS, CITY, STATE, ZIP CODE \$24 ALLRED MILL ROAD MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 reviewance and ensured and if the part page 4 continued From page 31 continued From page 31 reviewance and ensured they were investigated and reported she logged the rievances and ensured they were investigated and resolved. The SW reported that new oncems were brought up in their morning clinical leeting. She reported that new oncems were brought up in their morning clinical leeting. She reported after the grievance work of the page 4 continued From page 31 continued From page 31 F 585 F	A BUILDING 345191 B. WING STREETADDRESS, CITY, STATE, ZIP CODE \$42 ALLRED MILL ROAD MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCY MIST BE REFECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 31 continued From page 31 colitity had run out of her pain medication Methadone) and Resident #21 had filed a rievance on 11/30/2023. This continued through the middle of February 2024. She reported the colitity had told Resident #21 the pharmacy had to sent it. She recalled her daughter calling her nultiple times during the night from December 023 until February 2024 hysterical and gightened because she was worried, she was not oing to get her medication. In interview was conducted on 3/22/2024 at 8:52 m with the SW. The SW stated staff are trained to complete a grievance form when a resident or saident representative (RR) voiced a concern. the grievance form should then be given to a peartment head or placed in an administrative naibox. She was provided with a copy of the rievances and ensured they were investigated not resolved. The SW reported that new oncerns were brought up in their morning clinical neeting. She reported after the girevance rievances and ensured they were investigated not resolved. The SW reported that hey not a peartment head or placed in an administrative naibox. She was provided with a copy of the rievances and ensured they were investigated not resolved. The SW reported that hey girevance if reverse she the girevance or rievance and reported she the girevance as filed by a RR, they would contact the resident not have the provided and if the girevance as filed by a RR, they would contact the resident #21 in the RR. She stated girevance if or riginal grievance form in the girevance log but as not able to recall if Resident #21 or the RR ad been notified of the outcome. In interview was conducted on 3/20/2024 at 0.050 am with the Administrator reported that	

	OF DEFICIENCIES CORRECTION			B) DATE SURVEY COMPLETED		
		345191	B. WING			C
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	<u> </u>	03/27/2024
(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 CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 585	grievance should conshould give the form grievance should the department. After an or resident represent with. She reported the would investigate and involved their department head was responsible resident and/or RR. The Administrator was Jeopardy on 3/21/202. The facility submitted credible allegation of removal. Identify those recipies are likely to suffer, as a result of the noncordinate of the fame of the	Inplete a grievance form and to a supervisor. The in be given to the appropriate investigation, the resident attive should be followed up not each department head it resolve grievances that ment, and the department it is for following up with the instance of Immediate 24 at 6:25 pm. If the following acceptable immediate jeopardy Into who have suffered, or serious adverse outcome as impliance: In ance was filed for Resident cility ran out of her ector of Nursing (DON) one was present on the over documentation had been was no further follow-up rievance form and an completed. An interview 19/24 with DON. The DON int to the medication cart on one was in the medication Methadone had been Medication Administration	F 58			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	I	03/27/2024
(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 CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 585	complaints that the fill Methadone frequent has not experienced Methadone since he The resident states not having her medicompleted. - On 3/22/24 the Add Grievances for the prievance process to was completed per process or system from the process or system from the action will states outcome from the action will states outcome from the action will states outcome from the action will on 3/22/24 by the December of Clinical, Social Work Nursing (ADON), Regional Operations of Clinical in-service Resident and Family importance of follow investigation on all Contracking the grievance and providing writter responsible party by the Don, ADON, Regional Nurse on Staff on ensuring the reported according to Grievances policy and foreign and grievances policy and Grievances policy and foreign and grievances policy	conal Nurse related to her past facility runs out of her ly. Resident stated that she is the facility running out of er complaint in November. It is that she is no longer in fear of cation. Full Grievance ministrator audited least 3 months to ensure the principal in include the investigation policy. The entity will take to alter the failure to prevent a serious for occurring or recurring, and the complete: The sand procedures on the grievance of the participants on the grievances policy and the consultant, and the participants on the grievances policy and the	F5	585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STA 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	·	03/2//2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 585	ADON will be respondant and has not bee the education thems. Administrator, Regio Clinical to assist with Staff and/or agency during orientation or assignment. Alleged date of IJ remondant of the past three more grievance with reside that facility ran out of reported has not hap complaint and is not her medications. On 3/22/24 the Administrator and Done of the past three more grievance process and completed per policy procedures on Reside were reviewed on 03 Administrator, Social Nurse Consultant, Remondant of the policy procedures on the	usible for keeping up with who in in-serviced and completing elves or assigning the nal Operations or VP of training as needed. All New staff will also be in-serviced before taking a resident moval: 3/23/24 dility's immediate jeopard e 03/23/24 was validated w, interviews and the spinnal Nurse completed a ent related to past complaints Methadone. Resident pened again since her onger in fear of not having mistrator audited Grievances on the and ensured the end investigation was and the end investigation was are the facility policies and tent and Family Grievances w/22/24 by the DON, Worker, ADON, Regional engional Operations, and VP of Clinical in-serviced the DN on Resident and Family end importance of following attion and track the clusion and written decision	F	585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345191	B. WING			l	C 27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030	1 03/	21/2024
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F 585 F 600 SS=D	received education regrievances per the fain-service sheets veri education provided by with assistance from interview with the Adrrevealed that all training across all department be completed before grievances present definitions.	ras confirmed they had regarding reporting cility policy. Review of fied that staff had received by the administrative team the VP of Clinical. An eministrator and the DON and had been completed as and staff were required to their next shift. No currents curing validation to review.		585			4/24/24
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's message of the second second involuntary seclusions. This REQUIREMENT by: Based on record revious contractions and the second record revious contractions.	involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced ew, staff and Medical are facility neglected to order for intravenous fluids			 Immediate action(s) taken for the resident(s) found to have been affected include: The facility failed to implement a physician □s order for intravenous fluids 		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345191	B. WING			C 03/27/2024	
		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	03/2//2024	
		542 ALLRED MILL ROAD			
CENTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	DATE	
led: -referenced to: -cord review, staff and Medical , the facility failed to implement or intravenous fluids. The vas for 1 of 3 sampled	F 6	for resident #255. Resident #2 longer resides in the facility. 2. Identification of other residence the potential to be affected was accomplished by: " All residents who are order intravenous fluids have the potential affected by this deficient praction was performed of all current residents are currently residents are currently residents. 3. Actions taken/systems put to reduce the risk of future occinclude: " The Director of Nursing, A DON, VP of Clinical, Administr Manager and/or Regional Nursinservice RNs and LPNs on the Intravenous Therapy policy and that all residents with orders for receive their IV therapy timely ordered per the physician. " All new RNs and LPNs will serviced on these items and poduring the orientation process or ADON. " Any RNs or LPNs who has through the training prior to the compliance date will have to doworking again. " Any Agency staff will be enprior to working	dents haves ered tential to dee. An auterial to dee. An auterial to deceiving I' t into place currence assistant reator, Unit de ensuring or IV there and as II be in colicies by the Do ve not we de o so prior ducated (s) will be	be udit No V Ce the segrapy ON ent to to	
		A. BUILDIN 345191 B. WING CENTER BY HARBORVIEW STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) A. BUILDIN B. WING PREFIX TAG F 6	A BUILDING 345191 STREET ADDRESS, CITY, STATE, ZIP CODE \$42 ALLRED MILL ROAD MOUNT AIRY, NC 27030 STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) Bage 36 F 600 F 600	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 STATEMENT OF DEFICIENCIES PROCYMUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) FREFIX TAG FOOD FOR STREET REPROCED TO THE APPROPRIA DEFICIENCY) FOOD FOR THE APPROPRIA DEFICIENCY A BUILDING FREFIX TAG FOOD FOR TESIDENT FYING INFORMATION) FOOD FOR TESIDENT FYING INFORMATION) FOOD FOR TESIDENT FYING INFORMATION FOOD FOOD FOOD FOOD FOOD FOOD FOOD F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED		
		345191	B. WING			C 03/27/2024		
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
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F 602 SS=K	§483.12 The resident has the neglect, misappropriand exploitation as dincludes but is not lincorporal punishment any physical or chemitreat the resident's many many many many many many many many	riation/Exploitation right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to	F 6	ADON, VP of Clinical and/or Nurse beginning 4/18/2024 w intravenous fluid orders 5 day for 12 weeks to ensure all ordintravenous fluids are implem ordered. " Any deficient practice for the audits will be corrected in and education and/or correctidone by the DON as appropr " The Audit findings will be the DON in a Monthly QAPI minimum of 3 months. 5. The Administrator is responsible the execution of this plan will compliance date of 4/24/2024	vill review all ys per week ders for mented as und during mediately ive action iate. The reported by meeting for a consible for the en affected ugs were 22/24 by the	4/24/24		

PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
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		343191	B. WING _		· · · · · · · · · · · · · · · · · · ·	3/27/2024	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL)Ε		
SURRY C	OMMUNITY HEALTH	CENTER BY HARBORVIEW		542 ALLRED MILL ROAD			
oom o				MOUNT AIRY, NC 27030			
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F 602	Continued From page	age 38	F6	02			
F 602	her Methadone (ar #3 would tell her the medication and ne (7:00 pm to 7:00 a Medication Admini 11/2023 through 0 #21's Methadone was assigned to the dispensary reports facility's narcotic set two missing cards that could not be a signed on the dispensary reports facility's narcotic set wo missing cards that could not be a signed on the dispensary reports facility's narcotic set was not administed experienced terribi on a scale of 1 to had nausea and a anxiety was 'out the 'terrified all the time medications availate having withdrawals occurred for 1 of 2 misappropriation of facility staff. Immediate jeoparce the facility failed to misappropriation of facility staff. Immediate jeoparce the facility staff. Immediate jeoparce at a lo (no actual harm withat is not immediate in the medication in the facility staff. Immediate jeoparce in the facility staff.	nalgesic opioid agonist), or MA nat she would bring her pain ver return during the night shift m). Review of Resident #21's stration Record (MAR) for 2/14/2024 revealed Resident was signed out as administered e (MA) #3 every night shift she he resident. Review of from the pharmacy and the ign out sheets demonstrated of Resident #21's Methadone her decounted for which were ensary report as received by hident #21 reported when she red her Methadone, she he/awful pain of greater than ten 10, was crying during the night, headache, and reported her he roof because she was he' that she would not have her ble, and she thought she was he' that she would not have he' that she would not have he' that she	F 6	2. Identification of other resid the potential to be affected w accomplished by: • The facility has determined residents have the potential t affected. • On 3/22/24 the Social Work questioned all residents with an 8 to see if there were any residents complaint type of misappropriation or exinclude but not limited to identity thef theft, credit card theft, coerce medication theft or any type of theft of re property. If identified, the adminitiate all reporting and investigative propolicy. The Director of Nursin an audit on 4/18/24 of all residents comedications and determined were none missing at that time. 3. Actions taken/systems put reduce the risk of future occurricude: • The VP of Clinical on 3/22/2 the Administrator, Director of Assistant Director of Nursing and Sociathe Abuse, Neglect and Explowhich outlines types of Misappropri Exploitation and reporting resand procedures to follow.	that all oo be der BIMS above and any exploitation to the control of the control		

Facility ID: 953479

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
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		345191	B. WING _			03/	27/2024	
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SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		M	OUNT AIRY, NC 27030			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 602	F 602 Continued From page 39		602					
	Findings included:				Director of Nursing and/or Regional Nu began in person			
		dmitted to the facility on			educating on 3/22/24 all facility staff or the Abuse, Neglect and Exploitation po			
	5/26/2023 with diagn	the lower half of the body,			which outlines types of Misappropriation,			
	anxiety disorder, here				Exploitation and reporting responsibiliti	es		
		ain), major depressive			and procedures			
		eadache, chronic pain			to include reporting any type of abuse			
	syndrome, and opioio	a dependence.			immediately to their immediate supervi Administrator or Director of Nursing	sor,		
	A review of Resident	#21's physician orders			directly or by phone on nights or			
	revealed the following				weekends. Supervisors			
					will notify the Administrator and/or DON	1		
		/2023 through 12/18/2023			directly or by phone on nights or			
	for Methadone 35 mi at bedtime (9:00 pm)	lligrams to be administered			weekends. Phone contact information is posted at both			
	at beduine (9.00 pm)	тог рапт.			nurses stations. The DON and/or ADO	N		
	An order dated 11/1/2	2023 through 12/18/2023 for			will be			
		ams to be administered two			responsible for keeping up with who ha	IS		
	times per day (6:00 a	ım and 2:00 pm).			and has not been inserviced and completing the			
	A quarterly Minimum	Data Set (MDS) dated			education themselves or assigning the			
	11/20/2023 revealed	Resident #21 was			Social Worker, Administrator, Regional			
	cognitively intact. It v	was documented that			Nurse, Regional			
		ed opioid medications daily			Operations or VP of Clinical to assist w	ith		
	during the 7-day look	back period.			training as needed. Social Worker,			
	Review of a grievance	e dated 11/30/2023 received			Administrator, Regional Nurse, Regional Operations of	nr.		
	by the Business Office				VP of Clinical were notified of this on	"		
	_	d the facility was running out			3/22/24.			
	of her Methadone. T				All staff inserviced again starting 4/18	/24		
		e grievance form noted			by the DON, ADON, VP of Clinical,			
		ne medication cart and had			Administrator,			
		er documentation. The			Unit Mangers and/or Regional Nurse o			
		OON) signed the grievance			the Abuse, Neglect and Exploitation po	licy		
		ther investigation, summary conclusions or the date the			which outlines types of Misappropriation,			
		issued were documented.			Exploitation and reporting responsibiliti	es		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C 27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET AL	DDRESS, CITY, STATE, ZIP CODE	1 007	2172024	
				542 ALLR	RED MILL ROAD			
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW			AIRY, NC 27030			
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F 602	12:18 pm with Resider reported starting the was told by a night sl Aide (MA) #3, that the Methadone, the phar of her pain medication would tell her that she medication and never frequently beginning Resident #21 reported time without getting herodomous from the feet of	aducted on 3/18/2024 at lent #21. Resident #21 end of November 2023 she nift staff member, Medication e facility had run out of her macy had not sent enough in at one time, or MA #3 e would bring her pain in December of 2023 and in the staff member of 2023 and in the staff with the staff on her behalf (11/30/2023). It is considered to the staff on her behalf (11/30/2023). It is considered by meadache during the time of her Methadone, and feeling ong through withdrawal.	F 6	and properties and pr	ediately to their immediate supervinistrator or Director of Nursing on the on nights or weekends. Pervisors will notify the Administrator or DON directly or phone on nights or weekends. The contact information is posted at nurses ons. The prevent Misappropriation of rolled medications all Nurses and dications Aides on the Controll of Regional Nurse on the Controll of Regional Nurse on the Controll of Regional Nurse on the Controll of Stance Administration and puntability policy, ortance of accurate reconciliation of rolled substances and proper reduce of medications. The inservice and/or controlled medications. The inservice ded that the nurses or a nurse and med aide we the packing slip verifying that the until over the proper parameters of the packing slip verifying that the until over the packing slip verifying the packing slip verify	f isor, or t /24 ed of g cotic n of vill unt s		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	•	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.22		
				542 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
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F 602	A follow-up interview 3/20/2024 at 11:19 a Resident #21 reporte getting her Methador or before Christmas weeks ago. She rep December MA #3 was every night and woul Methadone. She repespecially, she experience the waist down to blow up.' Resident during the night and experienced pain and	aff about this and none of aff came to speak with her. was conducted on my with Resident #21. and she remembered not an eat night beginning around and ending three to four corted during the month of as assigned to her hall almost don't bring her scheduled corted, in December rienced terrible/awful pain and felt like she was 'going to #21 reported she would cry vocalized every time she	F 60	and Med Aide sign that the sheet we added and correct the count of controlled medisheets/cards. The count will be verified before the start of each shift as the shift- to -she count of controlled medications is completed. If the count of controlled sheets/cards is the DON or ADON must be called a investigation done prior to the off growners leaving. The only people who remove sheets and or discontinued meds or empty from the cart is the DON, ADON or Regional Nurse. The DON, ADON or Regional Nurse check all medication carts Monday through Friday	cation fied nift wrong and an bing b can cards		
	pm with Resident #2 Resident Representa #21 was continuousl facility had run out of (Methadone) beginni Resident #21 filed a through the middle o reported the facility h pharmacy had not se daughter calling her night from December hysterical and frighte worried, she was not The RR recalled spe Assistant Director of facility running out of in December and the unaware of the issue #21 had been running	1's representative. The ative (RR) reported Resident y told on night shift that the her pain medication		to remove any discontinued or come cards and sheets and sign off on the Count Sheet Log. • All new Staff will be in serviced or items and policies during the orient process by the DON or ADON. • Any staff who has not went through training prior to the compliance date have to do so prior to working again. • Any Agency staff will be educated to working. 4. How the corrective action(s) will monitored to ensure the practice will recur: • The Administrator, Social Services Director and/or Director of Nursing conduct beginning 4/18/2024 a range	these ation the the ewill prior be ll not swill		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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				IV	MOUNT AIRY, NC 27030		
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F 602	Continued From page	e 42	F 6	502			
	Resident #21 had not out of Methadone sin ago. A review of the Physic	r concerns. She stated reported the facility running ce about three or four weeks cian Assistant (PA) note			interview of ten residents weekly for fo consecutive weeks then ten resident's biweekly for 2 months. These residents will be interviewed about possible abuse that they have experienced regarding	ur	
	Resident #21 was pla Resident #21 had exp	Resident #21 revealed aced on rounds for anxiety. Dressed frustration that her e not being given to her and			misappropriation of controlled medications. • Any deficient practice found during the audits will be corrected immediately ar		
	stated "I should have been told it was the last one [Methadone]. It's just a death sentence." The PA had written that medications had been ordered.				education and/or corrective action done by the Administrator as appropriate.		
		ducted on 3/21/2024 at			The Audit findings will be reported by Administrator in a Monthly QAPI meeti		
	PA reported she saw	ysician Assistant (PA). The Resident #21 for mandated			for a minimum of 3 months.		
	arise. She reported a had discussed taperir because she wanted	to get off it. The PA was			5. The administrator is responsible for execution of this plan with a compliand date of 4/24/2024	e	
	not getting her pain m not suspected any iss reported if Resident #	lent #21 reporting she was nedication at night and had sues with diversion. She 121 had reported increased					
	write another script to had the medications	k with the Unit Manager, and ensure that the resident she needed. The PA was details about what she					
	remember Resident # having increased pair	2/12/2023 and did not 21 saying that she was at night. She reported ntioned being started on					
	Methadone was a 'de	ath sentence' because she stop taking it and would be					
		note dated 12/18/2023 for d she was placed on rounds					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 602	told that insurance hauthorization specific she had been on for #21 had told her "I was never started me on A physician order darevealed an order for administered three tipm, and 9:00 pm) for A PA note dated 1/5/revealed chronic pair relatively stable. Resincreased pain prima working with physical A quarterly Minimum 2/13/2024 revealed I intact. It was docume received opioid med 7-day look back periodated 2/29/2024 for chronic pain was conschedule three times medication) twice daneeded. He reported stable on Ativan (and An interview was conpm with MA #3. MA longer employed at the terminated approximal reported when medications, arrived medications, arrived.	e PA noted the resident was ad requested a prior cally on Methadone which quite some time. Resident rish hospice would have it [Methadone]." ted 12/18/2023 to current resident methadone 30 mg to be mes per day (6:00 am, 2:00 repain. 2024 for Resident #21 neand anxiety appeared sident #21 reported some arily at night and while all therapy. Data Set (MDS) dated Resident #21 was cognitively ented that Resident #21 ications daily during the od. cal Director's (MD) notes Resident #21 revealed her introlled on Methadone is daily, Lyrica (nerve pain illy, and hydromorphone as defined the resident anxiety on 2/29/2024 as	F 60	02		

OF DEFICIENCIES CORRECTION	` IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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Continued From pag	e 44	F 60	2			
would put her name sheet and packing sto the narcotic book #3 verbalized she did Resident #21 from the Resident #21's Method Resident #21 would and would be out for She reported the iss being discharged from insurance requiring a medication. MA #3 in narcotic sign out she verbalized that there	on the narcotic sign-out lip and would add the sheets on the medication cart. MA d receive medications for the pharmacy, including adone. MA #3 reported run out of Methadone a lot that a couple of days at a time. The was due to Resident #21 m Hospice services and her that prior authorization for the the reported she did initial any the should have been two					
She was not able to reports only containe were discrepancies I	explain why the dispensary ed her signature or why there between the narcotic sign out					
am with Nurse #2. N worked on night shift verbalized residents, 300-hall would often receive their medica assigned to them. S was a good historian the resident's concein Nurse #2 did not have they did not report the An interview was con am with Nurse #3. N worked with MA #3 of suspected MA #3 ha	Nurse #2 reported she had twith MA #3. Nurse #2, including Resident #21, on report that they did not tions when MA #3 was he indicated Resident #21 and Nurse #2 did not report rns to administrative staff. We an explanation for why he resident's concerns. Inducted on 3/20/2024 at 7:08 Nurse #3 reported she had on night shift and had d not given residents all their					
	ROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENC REGULATORY OR Continued From pag reported the medical would put her name sheet and packing sl to the narcotic book #3 verbalized she did Resident #21 from the Resident #21 would and would be out for She reported the iss being discharged from insurance requiring a medication. MA #3 in narcotic sign out she verbalized that there signatures for the resignatures for the residents. 300-hall would often receive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to them. Swas a good historian the resident's conceive their medicar assigned to the residen	TORRECTION IDENTIFICATION NUMBER:	ROVIDER OR SUPPLIER DMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 reported the medications were counted, she would put her name on the narcotic sign-out sheet and packing slip and would add the sheets to the narcotic book on the medications for Resident #21 from the pharmacy, including Resident #21's Methadone. MA #3 reported Resident #21 would run out of Methadone a lot and would be out for a couple of days at a time. She reported the issue was due to Resident #21 being discharged from Hospice services and her insurance requiring a prior authorization for the medication. MA #3 reported she did initial any narcotic sign out sheets that she received and verbalized that there should have been two signatures for the receiving portion of the sheet. She was not able to explain why the dispensary reports only contained her signature or why there were discrepancies between the narcotic sign out sheet and the pharmacy dispensary reports. An interview was conducted on 3/20/2024 at 6:25 am with Nurse #2. Nurse #2 reported she had worked on night shift with MA #3. Nurse #2 verbalized residents, including Resident #21, on 300-hall would often report that they did not receive their medications when MA #3 was assigned to them. She indicated Resident #21 was a good historian and Nurse #2 did not report the resident's concerns to administrative staff. Nurse #2 did not report the resident's concerns. An interview was conducted on 3/20/2024 at 7:08 am with Nurse #3. Nurse #3 reported she had worked with MA #3 on night shift and had suspected MA #3 had not given residents all their medication due to how quickly she completed her	ROWDER OR SUPPLIER OMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 44 reported the medications were counted, she would put her name on the narcotic sign-out sheet and packing slip and would add the sheets to the narcotic book on the medication cart. MA 33 verbalized she did receive medications for Resident #21's Methadone. MA #3 reported Resident #21's Methadone. MA #3 reported Resident #21's would run out of Methadone a lot and would be out for a couple of days at a time. She reported the bissue was due to Resident #21 being discharged from Hospice services and her insurance requiring a prior authorization for the medication. MA #3 reported she did initial any narcotic sign out sheets that she received and verbalized that there should have been two signatures for the received proportion only contained her signature or why there were discrepancies between the narcotic sign out sheet and the pharmacy dispensary reports. An interview was conducted on 3/20/2024 at 6:25 am with Nurse #2. Nurse #2 reported she had worked on night shift with M4 #3. Nurse #2 verbalized residents, including Resident #21 was a good historian and Nurse #2 did not report the resident's concerns to administrative staff. Nurse #2 did not have an explanation for why they did not report the resident's concerns to administrative staff. Nurse #2 did not have an explanation for why they did not report the resident's concerns to administrative staff. Nurse #3 flore for the resident's concerns. An interview was conducted on 3/20/2024 at 7:08 am with Nurse #3 no night shift with safe and worked with MA #3 and not given residents all their medication who quickly she completed her	A BUILDING COMPLETED COMMUNITY HEALTH CENTER BY HARBORVIEW SIMEMARY STATEMENT OF DEPRICENCIES (EACH OPENCIANCY) SUMMARY STATEMENT OF DEPRICENCIES (EACH OPENCIANCY) SUMMARY STATEMENT OF DEPRICENCIES (EACH OPENCIANCY) REGULATORY OF LISC IDENTIFYING INFORMATION) Continued From page 44 reported the medications were counted, she would put her name on the narcotic sign-out sheet and packing slip and would add the sheets to the narcotic book on the medication for Resident #21 from the pharmacy, including Resident #21 the bing discharged from Hospies services and her insurance requiring a prior authorization for the medication. MA #3 reported she did receive be services and her insurance requiring a prior authorization for the medication. MA #3 reported and verbalized that there should have been two signatures for the receiving portion of the sheet. She was not able to explain why the dispensary reports only contained her signature or why there were discrepancies between the narcotic sign out sheets that a the received and verbalized that there should have been two signatures for the receiving portion of the sheet. She was not able to explain why the dispensary reports only contained her signature or why there were discrepancies between the narcotic sign out sheets that also receive their medications when MA #3 was assigned to them. She indicated Resident #21 was a good historian and Nurse #2 did not report the resident's concerns. An interview was conducted on 3/20/2024 at 7:08 am with Nurse #2 was a sold historian and Nurse #2 did not report the resident's concerns. An interview was conducted on 3/20/2024 at 7:08 am with Nurse #3 in this third and had suspected MA #3 had not given residents all their medication we took took yet when the medication were took the had worked with MA #3 on night shift and had suspected MA #3 had not given residents all their medication to the took over the tresident she had worked with MA #3 on night shift and had suspected MA #3 had not given residents all their medications were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
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F 602	not getting their me MA #3. She indicat historian and Nurse residents saying the medication to anyor explanation for why resident's concerns. A review of MA #3's time for every day in 31 days she was as An interview was common with NA #2. NA with MA #3 on night would frequently received and with NA #2 that is scheduled pain medication for why #21's concern. A phone interview was a hall nurse and the facility until Octom MA #3 would routing 300-hall (Resident #2 verbalized residents MA #3 had not give medications from A facility in October 20	#21, had told her they were dications when assigned to ed Resident #21 was a good #3 did not report the ey had not received their ne. Nurse #3 did not have an she did not report the timecard revealed reported in December of 2023 and 28 of signed to Resident #21. Inducted on 3/21/2024 at 8:04 #2 reported she had worked it shift. NA #2 reported she ceive complaints from the was not getting her dication during the night shift. It this complaint to	F	602			
	the medications as when she would ap residents not receiv	given. Nurse #4 explained proach MA #3 about the ing their medications, MA #3 ad pulled and documented					

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F 602	Nurse #4 reported s back and administer residents would correceived their media #3. Nurse #4 stated dates, but she had ADON on several or don't have any help what to do.' Nurse to the Administrator care of it.' An interview was copm with the Pharma audited approximate monthly when he vipharmacist reported narcotic sign-out she the medication cart validate narcotic signeports from the phasuspected diversion conversation with n facility. The Pharmare	ge 46 ut had not given them yet. she would not see MA #3 go r the medications, and ntinue to tell her they never cations when assigned to MA d she could not recall specific reported the issue to the ccasions and was told 'we just on third shift, I just don't know #4 also reported her concerns who told her 'We will take and ucted on 3/20/2024 at 3:09 acist. He reported he randomly ely three narcotic sheets sits the facility. The d he strictly looked at the neet and medication card on . He reported he did not gn-out sheets with dispensary armacy. He verbalized if he n that he would have a ursing management in the acist did not recall being made ng narcotics or the facility	Fé	SO2		
	An interview was community and with the ADON. during November a frequently come to Director of Nursing ADON stated she do her residents were when assigned to Moreover pulling medications administered without an interview of Residents.	dent #21's Methadone. Inducted on 3/21/2024 at 9:21 The ADON reported that Ind December staff would Inducted on 1/21/2024 at 9:21 The ADON reported that Ind December staff would Inducted on 1/21/2024 at 9:21 The ADON reported that Inducted on 1/21/2024 at 9:21 Inducted on 1				

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F 602	every day. The AD come in at 3:00 pm (16-hour shifts) more reported MA #3 had medications, includ from the pharmacy been reported by noregarding Resident only able to recall Freporting Resident was unable to remestated 'the pharmacout of Methadone. That the facility had Methadone and the getting it.' The ADC investigated the RE never known the phout of Methadone. Not followed up with An interview was copm with the Director verbalized she was involving Resident in pharmacy dispense the narcotic sign out she that the pharmacy dispense the pharmac	oyed working and would work ON reported MA #3 would and work until 7:00 am st days of the week. She d frequently received ing controlled medications, and that no discrepancies had urses or medication aides #21's Methadone. She was Resident #21's Representative #21 was out of Methadone but ember when. The ADON by had never let the facility run The RR had reported to her run out of Resident #21's resident reported she was not ON reported that she had not R's concerns because she had harmacy to let the facility run She verbalized that she had in the RR. Onducted on 3/19/2024 at 3:16 or of Nursing. The DON not aware of a discrepancy #21's Methadone or that the lary reports did not align with at sheets for Resident #21. W, the DON reviewed the leets and compared them to lensary reports, she confirmed done were not accounted for so pharmacy dispensary report, and would be 'a whole sleeve of liso confirmed 25 tablets of lire card, card number 5 of 6)	F	502		
	medication.' She a Methadone (an ent were not accounted dispensary report.	lso confirmed 25 tablets of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
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F 602	dispensary dates, at diversion. An interview was cor am with the Administ not able to recollect a #3 and was unable to terminated. The Adminever made aware the medications and not including Resident #2 of any discrepancies substances. The Administrator reported 2/14/24 because she than any other staff rewhen they cut her how had attempted to get she could have their. An interview was cor am with the Corporat Nurse reported the ADON in controlled medication situation did not involverse did not recall as	ets for Resident #21 for both which point she suspected aducted on 3/21/2024 at 9:41 rator. The Administrator was any information regarding MA or remember why MA #3 was ministrator reported she was sat MA #3 was signing out giving them to residents, 21, and had not been notified involving controlled ministrator did not recall er concerns. The ad MA #3 was terminated on was working more hours member and became upset turs. She reported MA #3 other staff to call in so that hours. Inducted on 3/21/2024 at 9:45 are Nurse. The Corporate DON would call her with ON was on leave. She and called to report missing as in October 2023, but the live MA #3. The Corporate any complaints about MA #3	F	DEFICIENC'	<u>r)</u>		
	receiving their medic had never known the Methadone, but they forth with the pharma Methadone prior auth An interview was cor	did communicate back and acy regarding Resident #21's					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
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F 602	been a patient of his He reported that men pretty reliable historing at anxious, upset, a The MD reported that been a challenge for recall Resident #21 received her Methad The Administrator was Jeopardy on 3/21/20 The facility provided allegation of Immedial Identify those recipies are likely to suffer, a because of the noncontained that the facility with during the night shift Medication Administration of the staff. Resident #21 roled that the facility with Medication Administration and the night shift Medication Administration of the night shift Medication Administration and the signed out as given with the facilities narcotic significant revealed discreptispensary report from facilities narcotic significant reconciled on 3/21 revealed on 3/21/24 and faxed to 3/21/24 and fa	in t #21 and that she had in the primary care setting. dically Resident #21 was 'a an.' He reported she could and fixated on things at times. It pain management had years. He was unable to reporting she had not one at night. It pain management had years. He was unable to reporting she had not one at night. It pain management had years. He was unable to reporting she had not one at night. It protects following credible at Jeopardy Removal: Ints who have suffered, or serious adverse outcome compliance: In protect Resident #21 from controlled drugs by facility reported she was frequently resolved she was frequently resolved in Record revealed it was without omission by Med Aide arcotic sheets for Resident reaccies between the method the serious and the	F6	02		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 602	Continued From pa	ge 50 to this incident and the	F 6	502		
	Aide #3 on 3/21/24 - On 3/22/24 the Direported Nurse #5 the Nursing for possible in October 2023 On 3/22/24 the Soresidents with BIMS were any residents misappropriation or limited to identity the theft, coerced purch type of theft of residents administrator will in investigative process.	possible drug diversion by Med by the Director of Nursing. Trector of Nursing (DON) to the North Carolina Board of Drug Diversion that occurred social Worker questioned all Stabove an 8 to see if there complaining about any type of exploitation to include but not left, money theft, credit card mases, medication theft or any dent property. If identified, the litiate all reporting and dures per policy. The entity will take to alter the failure to prevent a serious om occurring or recurring, and				
	Administrator, Director of Nursing Abuse, Neglect and outlines types of Mi and reporting responsible. - The Director of Nursing and/or Regeducating on 3/22/2 Abuse, Neglect and outlines types of Mi and reporting responsible to their immediate states.	on 3/22/24 inserviced the ctor of Nursing, Assistant and Social Worker on the I Exploitation policy which sappropriation, Exploitation possibilities and procedures to arsing, Assistant Director of gional Nurse began in person 24 all facility staff on the I Exploitation policy which sappropriation, Exploitation possibilities and procedures to my type of abuse immediately supervisor, Administrator or directly or by phone on nights				

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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			03/2//2024	
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F 602	Continued From pagor weekends. Super Administrator and/or nights or weekends. posted at both nurse ADON will be responsa and has not been the education thems Worker, Administrat Operations or VP of as needed. Social Negional Nurse, Reclinical were notified and/or agency staff orientation or before assignment. Alleged date of IJ reconsistency and in revealed that the Reconsistency and in revealed that the Reconsistency and in the North Ca O3/22/24 of possible worker on 03/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O3/22/24 BIMS over an 8 if reconsistency and support the North Ca O4/24 BIMS over an 8 if reconsistency and support the North Ca O4/24 BIMS over an 8 if reconsistency and support the North Ca O4/24 BIMS over an 8 if reconsistency and support the North Ca O4/24 BIMS over an 8 if reconsistency and support the North Ca O4/24 BIMS over an 8 if reconsistency and support the North Ca O4/	ge 51 visors will notify the DON directly or by phone on Phone contact information is es stations. The DON and/or nsible for keeping up with who en inserviced and completing selves or assigning the Social or, Regional Nurse, Regional Clinical to assist with training Norker, Administrator, gional Operations or VP of d of this on 3/22/24. New Staff will also be inserviced during taking a resident moval: 3/23/24 cility's immediate jeopardy we 03/23/24 was validated by atterviews: On 03/22/24 egional Nurse checked and revealed no medication e notified on 03/21/24 by the ag diversion. The DON arolina Board of Nursing on a drug diversion. The social questions all residents with sidents had any concerns					
	concerns. The VP of serviced the Administration social worker on the policy. All staff recent Neglect, and Exploit types of Misapproprize reporting responsible DON, ADON, and R	n or exploitation and found no of Clinical on 03/22/24 in strator, DON, ADON, and Abuse, Neglect, exploitation ived training on Abuse, ation policy which outlines iation, Exploitation and lities and procedures. The egional Nurse began in 103/22/24 all facility staff on					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	RIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _		C 03/27/2024	
	IAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 602 Continued From page 52 abuse, neglect, and exploitation. Administrative staff interviewed and revealed they had completed the education of all staff. Interviews with staff from all departments revealed they had received training from administration staff. The IJ removal date of 3/23/24 was validated. F 603 SS=J F 603 SS=J The resident has the right to be free from abuse,					
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE COMPLETIC	N
F 602	abuse, neglect, and staff interviewed and completed the education	exploitation. Administrative I revealed they had ation of all staff. Interviews	F	602		
	received training fro The IJ removal date Free from Involuntar	m administration staff. of 3/23/24 was validated. y Seclusion	F	503	4/24/24	
	The resident has the neglect, misappropriand exploitation as concludes but is not line corporal punishments.	ation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and nical restraint not required to				
	physical abuse, corp involuntary seclusion	se verbal, mental, sexual, or				
	review, physician, pinterviews the facility #98 and Resident #3 seclusion when Medical Aide (NA) #2 placed activity/dining room closed, dim lighting, the residents' yelling residents were unable assistance. Resident diagnosed with deminterviews where the second residents were unable assistance.	lication Aide #1 and Nurse		1. Immediate action(s) taken resident(s) found to have beer include: • Resident #98 (BIMS 15) had assessment performed on 3/1 found no behaviors at the time and she was also a Geri psych NP provider on 3/1 assessed and evaluated. She was discharge house on 3/17/24. Resident #3 skilled assessment performed by nur.	a skilled 1/24 and sssessed by 1/24 d to hospice 305 had a	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		, ,	TE SURVEY MPLETED
	345191	B. WING		0:	C 3/27/2024
ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	, <u>, , , , , , , , , , , , , , , , , , </u>	
(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE
Continued From parapplied for this defireasonable person feelings of fear and to a room with no a practice affected 2 involuntary seclusion #305). Immediate Jeopard when Resident #98 placed in involuntary jeopardy was remonated facility implemented immediate jeopardy remain out of composeverity of "D" (no a minimal harm that it ensure education is systems put into plate the findings included A review of the facil Involuntary Seclusion Restraint" (Revised part the following:	ge 53 cient practice in that a would have experienced isolation from being confined bility to exit. This deficient of 2 residents reviewed for on (Resident #98 and Resident by began on Sunday 3/10/24 and Resident #305 were by seclusion. Immediate by seclusion. Immediate by a credible allegation of by removal. The facility will beliance at a lower scope and cactual harm with a potential for by sont Immediate jeopardy) to by completed and monitoring ace are effective. ced: lity's policy entitled "Identifying on and Unauthorized I September 2022) revealed in		3/11/24 that revealed no behavitime and was assessed and evaluated by the Psych NP provider on 3/11/24. #305 (BIMS 9) was assessed by the DON on 3 the residents stated that she way upset in any way from being in the activities room Resident #98 on the night in questive she was abused, neglected secluded in any way and is not any signs or symptoms of psychosocial probem Medication Aide #1 was called a DON on 3/20/22 at approximately 4pm and educated involuntary seclusion and ensure resident is ever involuntarily secluded. MA#1 was uspended pending investigation 3/20/24. The DON on 3/20/24 assessed the entire and determined that no resident being involuntarily secluded. On 3/20/24 the Social	Geri Resident 8/20/24 and as not n with estion. or showing lems. by the ed on ring that no as on as of building t was	
of a resident from or room or confinement resident's will or the representative. - Examples of in part: any attempt to certain area by blood Placing the resident a call light or other	other residents or from his/her int to his/her room against the ewill of the resident's legal evoluntary seclusion include in the keep a resident confined to a cking an exit or a closed door. It in an area without access to method of direct		BIMS above 8 about if they feel like they have secluded or isolated by the staff residents stated that they have never expinvoluntary seclusion. All reside visually inspected on 4/18/24 by the Dir Nursing and none were found to	ever been f. All of the erienced ents were ector of	
	Continued From parapplied for this defireasonable person feelings of fear and to a room with no a practice affected 2 involuntary seclusion feelings of fear and to a room with no a practice affected 2 involuntary seclusion feelings of fear and to a room with no a practice affected 2 involuntary seclusion feelings of fear and to a room with no a practice affected 2 involuntary seclusion feelings of fear and to a room with no a practice affected 2 involuntary seclusion feelings of "D" (no a minimal harm that it ensure education is systems put into plate the following: The findings included A review of the facil Involuntary Seclusion feelings included a resident from the representative. Examples of in part: any attempt to certain area by blood Placing the resident a call light or other communication with	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 applied for this deficient practice in that a reasonable person would have experienced feelings of fear and isolation from being confined to a room with no ability to exit. This deficient practice affected 2 of 2 residents reviewed for involuntary seclusion (Resident #98 and Resident #305). Immediate Jeopardy began on Sunday 3/10/24 when Resident #98 and Resident #305 were placed in involuntary seclusion. Immediate jeopardy was removed as of 3/22/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm with a potential for minimal harm that is not Immediate jeopardy) to ensure education is completed and monitoring systems put into place are effective. The findings included: A review of the facility's policy entitled "Identifying Involuntary Seclusion and Unauthorized Restraint" (Revised September 2022) revealed in part the following: "Involuntary Seclusion" is defined as a separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal	ROVIDER OR SUPPLIER DMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 applied for this deficient practice in that a reasonable person would have experienced feelings of fear and isolation from being confined to a room with no ability to exit. This deficient practice affected 2 of 2 residents reviewed for involuntary seclusion (Resident #38 and Resident #305). Immediate Jeopardy began on Sunday 3/10/24 when Resident #88 and Resident #305 were placed in involuntary seclusion. 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Placing the resident in an area without access to a call light or other method of direct communication with staff. Confining a resident to	ROWIDER OR SUPPLIER DMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 applied for this deficient practice in that a reasonable person would have experienced feelings of fear and isolation from being confined to a room with no ability to exit. This deficient practice affected 2 of 2 residents reviewed for involuntary seclusion (Resident #98 and Resident #305). Immediate Jeopardy began on Sunday 3/10/24 when Resident #89 and Resident #305 (BIMS 9) Immediate Jeopardy segusion. Immediate jeopardy was removed as of 3/22/24 when the facility implemented a credible allegation of immediate jeopardy was removed as of 3/22/24 when the facility implemented a credible allegation of immediate jeopardy year emoval. 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Confining a resident to the process of the process	A BUILDING 346191 346191 346191 346191 346191 346191 35TREET ADDRESS, CITY, STATE, ZIP CODE 52 ALLRED MILL ROAD MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (ECAL DEFICIENCY MUST BE PERCECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 applied for this deficient practice in that a reasonable person would have experienced feelings of fear and isolation from being confined to a room with no ability to exit. This deficient practice affected 2 of 2 residents reviewed for involuntary seclusion (Resident #98 and Resident #98 and State of the table was not upset in any way from being in the activities room with A review of the facility implemented a credible allegation of immediate jeopardy removal. 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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG		Ι,	c
		345191	B. WING				27/2024
NAME OF P	ROVIDER OR SUPPLIER	-1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	-
011001/04				54	42 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CI	ENTER BY HARBORVIEW		М	IOUNT AIRY, NC 27030		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 603	Continued From pag	ne 54	F	603			
		30 0 1	' '	000	2. Identification of other regidents having	20	
	convenience.	onfining a resident against his			Identification of other residents having the potential to be affected was	ig	
	or her will is prohibit	-			accomplished by:		
	or nor will is profiled	icu.			The facility has determined that all		
	a. Resident #98 was	s admitted to the facility on			residents have the potential to be		
		ses which included severe			affected.		
		tion, bipolar disorder, anxiety			3. Actions taken/systems put into place	to	
	_	f adult personality and			reduce the risk of future occurrence		
	behavior, hemiplegia and hemiparesis following				include:		
	cerebral infarction (stroke), muscle weakness,				 Current medication aides, RNs, licens 	sed	
	and need for assistance with personal care.				nurses and CNAs received training on Identifying	the	
	Review of the admis	ssion Minimum Data Set			Involuntary Seclusion and Unauthorize	d	
	(MDS) dated 2/22/2	4 revealed Resident #98 was			Restraint policy and the Abuse, Negled	t,	
	cognitively intact, wi	th delirium sign/symptoms,			and		
		aviors. The MDS further			Exploitation policy which outlines types		
		98 was coded for physical			abuse and reporting responsibilities an	d	
		s directed toward other, and			procedures		
		directed toward others (i.e.,			to follow. Inservice began on 3/20/24.		
		directed toward self or			education was started on 3/20/24 by th	е	
		ms like screaming). The MDS nts' behaviors put the resident			Director		
		physical injury and put others			of Nursing, Assistant Director of Nursin and/or Regional Nurse.	g	
					• On 3/21/24 the Administrator, DON,		
	at significant risk of physical injury. The MDS revealed Resident #98 had rejection of care				ADON, Activities Director, and Social		
		red assistance with mobility.			Services Director		
					received education from the VP of Clin	ical	
	Resident #98's care	plan revised on 3/5/24			on identifying different types of abuse/	the	
		98's had displayed behaviors			seriousness of allegations, timely and		
	of hitting others and	screaming. Resident #98's			thorough abuse investigations and the		
		ons included: one on one as			importance of		
		ring medications as indicated,			implementing protection for all resident	S	
		situations or people that are			and assessing all residents after		
		nake sure resident is not in			allegations of abuse		
	·	ole, offer activities as			are made.		
	_	pative behaviors begin remove			All Nurses, CNAs and Medications Ai		
		nt activity, let the physician			(MAs) will be reeducated starting 4/18/	24	
		esident's behaviors are r living, offer the resident			by Director of Nursing, Assistant DON, VF) of	
	michiching with dally	nving, onei the resident	1		שווכטוטו טו ואטוסוווש, אססוסנמווג שטוא, VF	UI	1

NAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 603 Continued From page 55 something they like as a diversion. The care plan revealed Resident #98 was at risk for injury due to poor safety awareness and history of behaviors of wrapping things around herself. Her care plan further indicated she was at risk for falls due to behaviors, poor safety awareness, and history of falls. The care plan goals included: to manage factors that increase risk for falls daily, Resident #98 will be safe in her environment, and will calm down with staff interventions. An interview was performed on 3/17/24 at 12:06 PM with Medication Aide #4. She stated they typically left Resident #98's room door closed and did not like to wake her up because she would yell/scream all day and "ramp the other residents up". She stated the resident yelled and screamed when she was awake. She stated Resident #98 was in a single occupied room and said they usually kept Resident #98's door closed in the morning and at night because other residents were trying to sleep. On 3/20/24 at 2:35 PM an interview was performed with NA #3 who was typically assigned to B hall. She stated Resident #98 was originally able to propel her wheelchair by scooting herself with her feet. She explained over the last 2 weeks Resident #98 add declined in condition and could!	(X3) DATE SURVEY COMPLETED	
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CALL DEFICIENCY MINITY HEALTH CENTER BY HARBORVIEW MOUNT AIRY, NC 27630		
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I NESIDENT #30 HAD DECIMED IN CONDUCTOR AND COURT TECH.		
Resident #98 be able to open doors. 4/18/24, will conduct an audit of all residents weekly		
typically assigned to work on B hall. She conducted to ensure that no residents are		
explained Resident #98 had a decline in condition in any form of involuntary seclusion.		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			С	
		345191	B. WING _			3/27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
SURRY C	OMMUNITY HEALTH (CENTER BY HARBORVIEW		542 ALLRED MILL ROAD			
0011111				MOUNT AIRY, NC 27030			
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F 603	Continued From pa	age 56	F 6	503			
	#98 had screaming not like to be alone Resident #98 liked one) and interventiher would help her Resident #98 was "maybe a few feet" chair with her feet. had never seen Redoor and was unsuout of a room with b. Review of Resides summary dated 3/6 with sundowning/a Resident #305 was 3/6/24 with diagnos weakness, and the personal care. Resident #305's ac dated 3/6/24 revea assistance with act transfers, and mobility.	g/ yelling behaviors and she did e. Medication Aide #2 said being with someone (one on ons "like sitting and talking to calm down". She said only able to move herself by scooting herself in her Medication Aide #2 said she esident #98 be able to open a ure if she would be able to get the doors closed. ent #305's hospital discharge 6/24 revealed she had "issues		audits will be corrected immeducation and/or corrective action dor Administrator as appropriate • The Audit findings will be r Administrator in a Monthly of for a minimum of 3 months. 5. The administrator is resp execution of this plan with a date of 4/24/2024	ne by the e. reported by the QAPI meeting onsible for the		
	dated 3/8/24 revea wheelchair. She re for ambulation and	Imission "Interim Care Plan" led Resident #305 used a quired two-person assistance transfers. The baseline care ident #305 was at risk for					
	required staff assis	3/8/24 revealed Resident #305 stance with personal hygiene ily living (ADL). Her care plan at risk for falls due to a history					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 3/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		3/2//2024
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F 603	Continued From pag		F 6	03		
	injury. The care plan assistance with ADL increase the risk of f Skilled nursing docu indicated under the Resident #305 had i thinking. The section was marked with psy. An interview was pe 3/20/24 at 6:00 AM. screaming behaviors by facility staff to clowhen she was screat told this by different provide the names of said Resident #305 screaming behaviors.	mentation dated 3/10/24 section labeled "cognition" nattention and disorganized n labeled "mood/ behavior"				
	at the top of A/B hall 6:15 AM. The observativity/dining room with a glass window be viewed from A-hat the door. The room oglass window leadin activity/dining room as 7 wall sconces. Wwas not on, the room observed at 6:15 AM provided very low lig room has an access a solid wooden door	e activity/dining room located was completed on 3/20/24 at vation revealed the had a door located on A-hall pane. The activity room could all hallway directly in front of contained an exit door with a g out to a courtyard. The had recessed lighting as well when the recessed lighting in was dim to dark when M. The 7 wall sconces thing. The activity/ dining door on B hall, the door was toosed. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	03/2//2024
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F 603	glass windowpane	ge 58 front entrance had double doors facing the nursing	F 6	503		
	recording of the inci #98 and Resident # Administrator, the R Operations, and the Administrator stated recorded. The video recording revealed the following - 7:13 PM: Resid wheelchair at the to next to the medication was facing down the camera. Medication medication cart prep #98 used her feet to about 45-degrees in so she was facing to positioned against to administered Reside - 7:17 PM: Medic Resident #98 into the	Corporate Nurse. The I there was no sound I date was 3/10/24 and				
	observed to be take with her 7:18 PM: Medic the activity/dining rodoors to the activity wooden door to B h - 7:23 PM: Reside paned doors at the room. Resident #98 on the video record.	cation Aide #1 walked out of com. The front glass paned / dining room were closed, the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/21/2024
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F 603	doors with her hand momentarily pushed the door protruding met in the center, but door open. She barn pane of the door. The who came to check - 7:26 PM: Resid activity/dining room room NA #2 moved front glass pane door oom and walked averamined open 7:31 PM: Nurse door on B hall and proom and then walk - 7:33 PM: staff viside of the wooden for the activity/dinimembers stopped of the room's doors 7:38 PM: NA #2 room side door at the glass paned doors to the room's doors 7:41 PM: a staff through the front glawalked away 7:41 PM to 8:20 walked by the activity or turn their head to - 8:21 PM: Nurse of the activity/dining Nurse #3 stopped an #1 8:27 PM: NA #2	en attempting to push on the and foot. The door was slightly ajar with the edge of forward from where the doors at she was unable to push the ged her hand on the glass here were no staff members on Resident #98. Hent #305 was pushed into the by NA # 2. While in the dining Resident #98 away from the first NA #2 then exited the first of the activity/dining fired doors at the top of B hall. If PM: 2 staff members walked first rurned their heads toward the first closed the wooden activity for the activity/dining room firmt from the activity/dining room from the staff of the activity/dining room from the staff member stopped and looked so pane doors, and then the PM: four staff members by/dining room but did not stop	F 60			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	343131	1 2		TREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2024
NAME OF PI	ROVIDER OR SUPPLIER						
SURRY CO	OMMUNITY HEALTH CEN	ITER BY HARBORVIEW			42 ALLRED MILL ROAD MOUNT AIRY, NC 27030		
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F 603	Continued From page	e 60	F	603			
	Throughout the video observed to bring sna activity/dining for the						
		4 where the facility was M (www.timeanddate.com).					
	at 9:37 AM with Medishe had been working AM) on 3/10/24. She Resident #98 and saithe end of B hall and screaming. She said for days and would so Medication Aide #1 sa	was performed on 3/20/24 cation Aide #1. She stated g night shift (7:00 PM- 7:00 explained she recalled d her room was located at she never stopped Resident #98 would scream cream during the night. aid, "no amount of doors to the residents' from hearing					
	[Resident #98] screar #98 did not like to be herself, and wanted s stated Resident #98 " room by herself. She able to calm her down station. She said she	n". She explained Resident alone, or in her room by omeone to be with her. She was scared" to be in her explained staff were usually by taking her to the nurse's sometimes brought					
	while she passed medown. Medication Aid around 8:00 PM she president #305, who the activity/dining roo	the medication cart with her ds, and she would calm e #1 stated, on 3/10/24 out Resident #98 and had also been screaming, in m together. She did not ts were provided with any					
	refreshments. She ex residents in the activity were yelling/screaming residents on the hall f staff could usually cal recently it had become screaming/yelling behavior	plained she put the ty/dining room because, they ag and keeping the other from sleeping. She stated m Resident #98 down but					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		345191	B. WING			C 03/27/2024		
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
(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 C ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 603	sleep. She said the todining room for about while the two resident room the screaming/two residents started. She said Nurse #3 would her the residents Medication Aide #1 so in the activity/dining rothen they were off (tillights above the televosaid the front doors to closed, but she though had been open. A telephone interview at 11:28 AM with NA worked night shift on remembered the incice Resident #305 and Roscreaming. She state usually have screaming unusual for her to be stated Resident #98 long. NA #2 explained to be alone in her roco on one with her, she calmed down. NA #2 was agitated and scregave Resident #98 her out to the nurse's with her; she explained helped calm Resident #305 in because they were set to be alone they were set they were set they were set to be alone they were set they were se	wo residents were in the tan hour. She explained ts were in the activity/dining yelling got worse when the screaming at each other. orking on A hall came and needed to be moved. tated she thought the lights soom were originally on, but me unknown) except for the rision (wall sconces). She of the dining room were ght the wooden door to B hall of was performed on 3/20/24 #2. She explained she	F	503				
	stated the TV in the a	nctivity/dining room had that the "lights that don't go						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	00/21/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 603	room. She explained activity/dining room originally open but, open the entire time room. She stated the room for about 45 n Nurse #3 brought Rehall. An interview was performed and with Nurse #3. Steep the night of 3/10/24 she was familiar with #305. Nurse #3 experimed as with her on A has at night. She said she will be with her on A has at night. Nurse #3 sisolated her. Nurse Medication Aide #1. remembered the ind 3/10/24. She said she was and yelling loudly. Note that the activity/dining room was dim to dark. She also in the dining room was dim to dark. She also in the dining room was dim to dark. She also in the dining room was dim to dark. She also in the dining room was dim to dark. She also in the dining room exact time but state 9:00 PM. Nurse #3 scared due to how secret in the state of the property was scared to how secret in the state of the property was scared to how secret in the state of the property was scared to how secret in the state of the property was scared to how secret in the property	vere on in the activity/dining and the wooden door to the that connected to B hall was she was unsure if it remained at the residents were in the e residents were in the dining ninutes. NA #2 explained esident #98 back down to B erformed on 3/20/24 at 7:05. She stated she had worked (7:00 PM- 7:00 PM). She said the Resident #98 and Resident lained Resident #98 had ehaviors and screamed/yelled the sometimes kept Resident all and did one on one with her tated they "had one girl who #3 identified the "girl" as She explained she sident from the night of the heard a resident screaming larse #3 stated she looked in from and Resident #98 was thair in the activity/dining room and all the doors to the were closed and the room the stated Resident #305 was form yelling. She stated there are taff members present in or dining room where the located. Nurse #3 verbalized ent #98 from the the was uncertain of the dit was between 8:00 PM-stated Resident #98 looked	F	503			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345191	B. WING				27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW	1	54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030	1 03/	21/2024
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F 603	the residents from the felt staff should not is right to be able to be She explained she waroom on B hall when her and said, "she ca has kept everyone up can't come down here the Medication Aide "here". Nurse #3 said her room and she qui assisted to bed. She and removed Resider and took her back to was unsure how long #305 were in the active had been "at least and there was not anyone facility during the night incident during shift of Aide #5 the following she also sent a phone Director of Nursing (Athe incident. She starmessage had been diback from the ADON, from the facility approximated incident. She indicate work on 3/13/24 Med and had continued to she "felt like the [Medicate work on 3/13/24 Medicate work on she brough the hall". She stated I #305 would not have activity/dining room be	She explained she removed edining room because she colate them and they had the in their rooms to go to bed. The as taking her back to her Medication Aide #1 stopped in the common to go to bed. The as taking her back to her Medication Aide #1 stopped in the common	F	603			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED		
		345191	B. WING			C 3/27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1	3/2//2024	
(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 CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 603	AM with Nurse #2. S working the night of the building and remexplained Resident # was another resident did not know the other #305). She stated the Resident #305 who wactivity/dining room, She said she was not room were open or could hear the reside side of the building. Side of the building. Side of the building. Side of the building. Side were the receival report on the morning who had worked night stated Nurse #3 told Aide #1 put Resident the activity/dining room. #305 were removed and when she had the hall Medication Aide #5 incident to the Assist (ADON). Medication did not like to be alor she yelled out more. #98's behaviors were was another resident worked on the personal resident when she had the her scream."	formed on 3/20/24 at 6:24 he said she had been 3/10/24 on the other side of embered the incident. She 498 was yelling and that there it yelling as well, she said she er resident's name (Resident e staff put Resident #98 and were yelling in the and staff had put the TV on. It sure if the doors to the losed. She explained she ents yelling from the other She said she felt placing two who were screaming/yelling ould agitate the residents. It was performed with on 3/20/24 at 3:40 PM. She ed (7:00 AM) shift change g of 3/11/24 from Nurse #3 out shift on 3/10/24. She her the following: Medication it #98 and Resident #305 in om with the doors closed. Hen screaming loudly in the Resident #98 and Resident from the activity/dining room when Resident #98 back to B #1 stated "don't bring her residents are tired of hearing tion Aide #5 stated she had called and reported the ant Director of Nursing Aide #5 said Resident #98 he and if she was by herself, She explained Resident	F 6	03			

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(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 603	the nurse's station to was not alone. She propel herself in her had never seen her Resident #98 had do having a stroke". Mesident #98 and For "absolutely not" be dining room if she had looked up abuse she explained after had looked up abuse google because the and stated, "when I exactly what it said. On 3/22/24 at 10:00 performed with the incident of Resident being placed in the had been reported to on 3/11/24. She state staff member able to one and the staff had the residents in the The ADON stated so frequent checks, an activity/dining room given the resident she frequent checks being placed in the had been reported to an additional to the staff had the residents in the The ADON stated so frequent checks, an activity/dining room given the resident she frequent checks being placed in the stativity of the resident she frequent checks being placed in the stativity of the resident she frequent checks being placed in the frequent checks being placed in the stativity of the resident she frequent checks being placed in the fre	often brought Resident #98 to o sit with her so Resident #98 explained Resident #98 could of chair very little and that she open a door. She explained eficits in her hands "from edication Aide #5 stated desident #305 would able to get out or leave the and wanted to without help. stated she felt like the and stated, "that is abuse". The incident occurred, she are and neglect definitions on incident had bothered her read the definitions that is abuse was." OAM an interview was ADON. She stated the activity/dining room by staff to her by Medication Aide #5 the there was not always a obe with Resident #98 one on and "tried the intervention to put activity room to socialize". taff had turned on the TV, did	F 60	03			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245404	B WING						
		345191	B. WING _		_	03/2	27/2024		
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OUTURE OF	Jillionii i neaein oei	WIER DI HARDORVIEW		MOUNT AIRY, NC 2703	30				
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F 603	Continued From page	e 66	F6	603					
	in the dining room wit Resident #305's histo	to leave the residents alone th the doors closed, with ory of falls and Resident and history of wrapping							
	Occupational Therap stated Resident #98 I therapy and services stated Resident #98's her stroke, she had v very poor safety awa yelling/screaming bel would sometimes ask yelling, and she would can't stop". She stated body was impacted b weak. She stated if R without assistance she the side affected by the could not support her explained Resident # side impacted by the functional use of her Resident #98 was discould scoot herself 10 She stated over the late #98 had declined in conseen her propelling hexplained over the late always seen Resident in her wheelchair by a she did not think Resident get out of the dining/a #1 also discussed Rehad completed the in	naviors. She stated they k Resident #98 why she was d tell them "I don't know I d one side of Resident #98's y the stroke and was very tesident #98 tried to get up ne would fall. OT #1 stated he stroke was very weak and without assistance. She 98's upper extremity on the stroke did not provide arm. OT #1 stated when scharged from therapy she 0-20 feet in her wheelchair. heast couple weeks Resident condition and she had not herself in her wheelchair. She st couple of weeks she had he #98 being pushed around he staff member. She stated he staff member. She stated he staff she would be able to he stident #305, she stated she he stroke and was very he was very he stated to get up he would fall. OT #1 stated he stroke was very he stored to get up he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he stroke was very he would fall. OT #1 stated he would fal							
	Resident #305 on 3/8	itial therapy evaluation for 3/24. The OT explained nition and safety awareness							

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		345191	B. WING _			C 03/27/2024		
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	00/21/2024		
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 603	cues for safety. The not propel herself we explained Resident do stuff but Resider and walk by herself. had falls since being to get up by herself. think Resident #305 the activity/dining roroom she was not fadim, being agitated being closed. An interview was performed and with Physical The She explained Resident glosed from her stroke had originally been distances in her who Resident #98 being distances. PTA #1 eweeks Resident #98 and since the declin #98 mostly being purchased agitation/not be able to get or discussed Resident been working in the explained Resident could not walk by he she stated she did said she recalled her stroke had originally been working in the explained Resident been working in the explained Resident could not walk by he she stated she did said she recalled her and walk processed she did said she recalled her and walk by he stated she did said she recalled her and walk by he stated she did said she recalled her and walk by he stated she did said she recalled her and walk by he stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her and walk by her stated she did said she recalled her said she r	e said she needed a lot of OT stated Resident #305 did ery far in her wheelchair. She #305 would try to get up and at #305 could not safely get up She stated Resident #305 g at facility related to her trying The OT stated she did not swould be able to get out of som by herself with it being a smilliar with, the lights being with screaming, and the doors erformed on 3/21/23 at 9:53 herapy Assistant (PTA) #1. dent #98 had been vices on 3/2/24. She #98 had deficits to her left she PTA #1 said Resident #98 able to propel herself short eelchair but had not observed able to propel herself any far explained over the last 2 shad declined in condition se she had observed Resident	F	503				

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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)

AND DUAN OF CORRECTION IN INCIDENTIFICATION NUMBER.		PLE CONSTRUCTION G	(X3) DATE SURV COMPLETED			
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	03/27/20	<u> </u>
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F 603	night". She stated, Nurse #8 stated she scared based on he and the tone of the was unsure if Resic Nurse #8 stated Rewould not have beed dining/activity room stated she felt Resi "secluded because "secluded because A telephone interviewith the Physician A She explained Resi yelling/screaming b "complicated case" responded best whwith her. She said valone she would state #98 was not able to without much help. thought placing Resident #98 was for provided one on on was not aware of the PA also discussed I she saw the resident said Resident #305 she would be able to dining room at night doors were closed, but I have not seen wheelchair". She saincident from 3/10/2 placing two residents	"it was a different tone". e felt Resident #98 had been ow loud the screaming was screaming. She stated she dent #305 appeared scared. esident #98 and Resident #305 en able to get out of the by themselves. Nurse #8 dent #98 and #305 had been of behaviors". ew was performed on 3/21/24 Assistant (PA) at 12:40 PM.	F 6	03		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW	•	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG			ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED			
F 603	appropriate, the PA s this would exacerbate An interview was con PM with the Medical facility had notified hi 3/10/24 when Reside had been placed in the staff due to yelling/so intervention had been lighting was good to also stated, Resident He said Resident #98 yelling if someone was but, as soon as they start screaming/yelling Director stated he was incident from 3/10/24 On 3/21/24 at 4:15 P performed with the D She was aware of the Resident #98 and #3 activity/dining room be was okay that staff had who were having screen into the activity/dining lighting, with the door she felt like this had been placed in the place of the performed with the D She was aware of the Resident #98 and #3 activity/dining room be was okay that staff had been placed in the placed in	rs closed alone would be tated, "probably not" and that at the behaviors. ducted on 3/21/24 at 1:19 Director. He stated the mof the incident from nt #98 and Resident #305 are activity/dining room by reaming. He said he felt the mappropriate and the low ry to decrease stimuli. He #98 did not like to be alone. It would stop screaming/ as with her and talking to her walked away, she would g again. The Medical s made aware of the on 3/20/24.		DEFIC 303	IENCY)		
	Resident #305 with a not think the intent wand Resident #305, s provide an activity to DON stated the staff because they had pla Resident #305 and p	n activity. She stated she did as to isolate Resident #98 he stated "I think it was to help with behaviors". The had provided an activity uced a TV show on for rovided Resident #98 a e did not indicate where she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C 27/2024
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F 603		e 71 ion about a drink being said she was unsure how	F	603			
	well Resident #98 columbia	uld maneuver her					
	door of the activity/dinto the door if Residen	ning room or be able to get at #98 did not have a railing stated she was unable to say					
	if Resident #305 wou activity/dining room a	Id be able to get out of the t night with it being dimly lit , she stated, "I cannot tell					
	you if she could do th						
	resident screaming/ye	elling loudly from a room she theck on them. She stated					
	_	taff to check on them.					
	Resident #98 did not stated Resident #98 di loved to be with peop would say "no don't le Director said Resider when she was with pour She stated she had now watch TV or enjoy was also discussed with stated Resident #305 activities. She said Resident #305 watch stated she did not this Resident #98 would eactivity/dining room at the lighting dim.	ctivity Director. She stated do many activities. She did not like to be alone, she die. She said the resident eave me". The Activity at #98's behavior was better eople who would talk to her. ever known Resident #98 to atching TV. Resident #305 with the Activity Director; she did not like to go to esident #305 wanted to stay ed she had not seen TV. The Activity Director ak Resident #305 or enjoy being in the lone with the doors shut and					
	·	formed on 3/21/24 at 4:40 rator. She verbalized she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				` '	3) DATE SURVEY COMPLETED	
			A. BOILDI	\G		(3	
		345191	B. WING _			1	27/2024	
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F 603	Resident #98 and placed in the activ stated the incident administrative nursinto it". She stated activity/ dining roo want the lighting to Resident #98 and having screaming/ She said administr different interventic screaming/ yelling unsure if staff had to placing the residents. She did expected staff to com. She stated residents. She did expected staff to communistrator state two residents with yelling/screaming together would exadministrator verb #98 had poor safe did not think the activation and the safe for her than and Administrator state #98 would have be dining room if she said she was unsuable to leave the awithout staff help. The facility's Adminiformed of the im 12:30 PM.	ncident from 3/10/24 when Resident #305 had been ity/dining room by staff. She had been reported to the sing staff and they had "looked it was never dark in the m. She explained she would be dim to decrease stimuli for Resident #305 who were yelling behaviors on 3/10/24. The properties of the residents behaviors. She stated she was tried the 1:1 intervention prior dents into the activity/ dining she expected staff to check on not elaborate on how often she heck on the residents. The ed she "could not speak on" if dementia who were being placed in a room alone accerbate their behaviors. The alized she was aware Resident ty awareness and stated she ctivity/dining room was any less my other space. The ed she did not think Resident een able to leave the activity/had wanted to by herself. She are if Resident #305 would be activity/ dining room by herself was the following credible diate Jeopardy removal:	F	503				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345191	B. WING				27/ 2024
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F 603	Continued From page	e 73	F	603			
	are likely to suffer, a a result of the noncor 3/22/24):	oients who have suffered, or serious adverse outcome as appliance. (Completion date					
	the citation and prever from suffering an adv Date: 3/22/24) " On 3/10/2024 Ref #305 were placed in a Medication Aide (MA) and recess lighting to were lit which provide Resident #98 and Ref no staff supervision. and Resident #305 in and yelling behaviors residents trying to sle	sident #305 were alone with MA #1 placed Resident #98 the room due to screaming which disturbed other tep on 200 hall. Resident ischarged to hospice house					
	assessed by the DON residents stated that way from being in the Resident #98 on the not feel like she was secluded in any way or symptoms of psych Medication Aide #1 w 3/20/22 at approxima involuntary seclusion resident is ever involuwas suspended pend 3/20/24. The DON of entire building and de was being involuntari Social Worker began	N on 3/20/24 and the she was not upset in any e activities room with night in question. She does abused, neglected or and is not showing any signs nosocial problems. ras called by the DON on tely 4pm and educated on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	03/2//2024
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 603	been secluded or is that they have been communicate with the	by feel like they have ever olated by the staff. If any say	F 6	503		
	process or system f adverse outcome from when the action will. The facility took the an adverse outcome (Completion Date: 3 The facility's po	following actions to prevent e from reoccurring. 3/22/24) blicies and procedures on				
	at approximately 3p Social Worker, ADC Consultant, Regiona Clinical. The VP of participants on the I Seclusion and Unau	aint was reviewed on 3/20/24 m by the DON, Administrator, DN/IP, Regional Nurse al Operations, and VP of Clinical in-serviced the dentifying Involuntary athorized Restraint policy and uring all residents are kept				
	nurses and CNAs w Identifying Involunta Unauthorized Restra of ensuring all resid Involuntary Seclusio 3/20/24 at approximensures that staff un residents free from residents from experimental procession of the staff of the sta	aint policy and the importance ents are kept free from on. Inservice began on nately 4pm. Education nderstand they must keep all Involuntary Seclusion to keep				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C
	ROVIDER OR SUPPLIER	EENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	I	03/27/2024
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F 603	aide, RN, CNA or li having gone throug will include agency Director of Nursing up the list of staff tr Medical Director wand Nursing services of Jeopardy related to Medical Directors having any concern Alleged date of immales of the services of the servi	fective 3/20/24 no medication censed nurse will work without the the in-service training. This staff and new staff. The will be responsible for keeping aining completion. The as informed by the Director of a 3/20/24 of the Immediate involuntary seclusion. The and no recommendations. On obtified Resident #305s bout the incident of Involuntary sed understanding and denied as. Inediate jeopardy removal: Incility's immediate jeopardy realidated through record review realidated by the following: On es policy and procedure on ary seclusion and unauthorized ewed by the DON, all Worker, ADON, Regional Regional Operations and VP of	F 6	03		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345191	B. WING _			C 03/27/2024	
NAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH CEM	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	<u>'</u>	33/2//2324	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
notification on 3/20/24 The facility's immedia 03/22/24 was validate	dical Director confirmed his 4. te jeopardy removal date of ed.	F 6			4/0.4/0.4	
and dignity, including: §483.10(e)(1) The rig physical or chemical r purposes of discipline required to treat the re consistent with §483. §483.12 The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemi treat the resident's me §483.12(a) The facility §483.12(a)(2) Ensure from physical or chem purposes of discipline are not required to tre symptoms. When the indicated, the facility r alternative for the lead document ongoing re- restraints.	and Dignity. That to be treated with respect to the straints imposed for the or convenience, and not the sident's medical symptoms, 12(a)(2). Tright to be free from abuse, and the sident's medical symptoms, 12(a)(2). Tright to be free from abuse, and the sident property, and the sident property, and the subpart. This sided to freedom from involuntary seclusion and itical restraint not required to the dical symptoms. That the resident is free the property is that the resident is free the property is the sident is free the property in the sident is free the sident is free the property in the sident is free the sident is fre	F 6	504		4/24/24	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345191	B. WING			C 03/27/2024
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2//2024
				542 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY 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 604	Continued From pag	e 77	F 60	04		
	facility failed to prote from unauthorized plactivities Director with administer a COVID Resident #15 was flat saying that she did in failed to identify a movement was practice in that a real experience feelings and dehumanization (depanded for 1 of 3 received for the right restraints. Immediate Jeopardy NA #1 was observed physically restraining	view and staff interview the ct a resident (Resident #15) hysical restraint when the tnessed Nurse Aide (NA) #1 test to Resident #15, while hilling her arms, resisting, and ot want a COVID test. NA #1 edical necessity that go a resident. The reasonable applied for this deficient sonable person would such as fear, pain, and privation of human qualities had being the deficient practice was sidents (Resident #15) to be free from physical began on 3/12/2024 when by the Activities Director greesident #15 to administer Resident #15 was flailing her		1. Immediate action(s) taken resident(s) found to have been include: • Resident #15 had a weekl assessment done on 3/13/24 to bruising or skin issues note was called by the DON on 3/20 approximately 6:45pm and edu Unauthorized restraint and enson resident is ever restrained was proper authorization from the Fand Responsible Party. NA#1 terminated as of 3/20/24. The Regional Operations and Region 3/20/24 assessed all reside determined that no resident had unauthorized restraint. On 3/2 Social Worker, MDS Nurse and Operations questioned all reside BIMS above 8 if they have everestrained against their will. All stated that they have not been	y skin hat showed d. NA #1 0/22 at ucated on suring that without Physician was VP of onal Nurse nts and is an 0/24 the d Regional dents with er been Il residents	
	arms, resisting, and a COVID test. Immeron 3/22/2024 when to credible allegation of removal. The facility at a lower scope and harm with the potent harm that is not immemployee education systems put into place. A review of the facility Seclusion and Unautron and COVID 10 test.	saying that she did not want diate jeopardy was removed the facility implemented a immediate jeopardy remains out of compliance I severity level "D" (no actual ital for more than minimal ediate jeopardy) to complete and ensure monitoring		A visual inspection by the Direct Nursing on 4/18/24 of all reside determined that there were not any form of unauthorized restract. Identification of other residente potential to be affected was accomplished by: The facility has determined residents have the potential to affected. Actions taken/systems put to reduce the risk of future occurrent medication aides, licensed nurses and CNAs rectaining on the Identifying Involved.	ctor of ents residents in aint. dents having s d that all be t into place urrence RNs, eived	

CENTER	3 FOR MEDICARE &	INIEDICAID SERVICES				OIVID INC	7. 0930-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345191	B. WING _			1	27/2024
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011551/ 04				54	2 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CE	ENTER BY HARBORVIEW		M	OUNT AIRY, NC 27030		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	<	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 604	Continued From pag	ne 78	Fe	604			
	_ ·	se of any physical restraints			Seclusion and Unauthorized Restraint		
		their medical conditions'.			policy and the Abuse, Neglect, and		
	The policy stated, 'so				Exploitation policy which outlines types	of	
	-	ntional, but this does not			abuse and reporting responsibilities an		
		he responsibility to recognize			procedures to follow. Inservice began		
		thorized use of restraints			3/20/24. This education was started or		
	which include holding	g down a resident in			3/20/24 by the Director of Nursing,		
	response to a behav	rioral symptom or during the			Assistant Director of Nursing and/or		
	provision of care if the			Regional Nurse.			
	refusing the care'. A			 On 3/21/24 the Administrator, DOI 	٧,		
	'inappropriate or una			ADON, Activities Director, and Social			
	occurs when it is use				Services Director received education fr		
		essarily inhibits a resident's			the VP of Clinical on identifying differen	ıτ	
		nt or activity, is not the least used for the least amount of			types of abuse/ the seriousness of allegations, timely and thorough abuse		
		is not accompanied by			investigations and the importance of		
	ongoing re-evaluatio				implementing protection for all resident	s	
	restraint.'				and assessing all residents after		
					allegations of abuse are made.		
	Resident #15 was ad	dmitted to the facility on			All Nurses, CNAs and Medications	; ;	
	10/29/2019 with diag	gnoses which included			Aides (MAs) will be reeducated starting	j l	
	vascular dementia, A	Alzheimer's disease, and			4/18/24 by DON, ADON, Administrator	,	
	generalized anxiety	disorder.			VP of Clinical, Unit Manger and/or		
					Regional Nurse on the Identifying	_	
	A review of Resident				Involuntary Seclusion and Unauthorize		
		rd (MAR) revealed a rapid			Restraint policy and the Abuse, Neglec	t,	
		viously been ordered and			and Exploitation policy which outlines		
	collected on 2/5/202	4.			types of abuse and reporting responsibilities and procedures to follow	١٨/	
	The guarterly Minimi	um Data Set (MDS) dated			The inservice will also include the	/v .	
		esident #15 was severely			importance of keeping all residents free	e	
		and had fluctuating behaviors			from all types of unauthorized restraints		
		n and disorganized thinking.			No resident, regardless of the		
					situation, will be placed in any type of		
	A review of the care	plan dated 2/6/2024 for			unauthorized restraint.		
		ed goals and interventions			 All new Nurses, CNAs and MAs w 		
	related to Resident #				be in serviced on these items and police		
		s, thoughts, and needs.			during the orientation process by the D	ON	
	Interventions include	ed staff were to ask Resident			or ADON.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY
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SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW			MOUNT AIRY, NC 27030		
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F 604	Continued From page	e 79	F	604			
F 604	#15 yes or no question to answer questions. revealed goals and in behaviors with intervercaregivers providing and attention. There interventions that insirefused care. A record review for R and did not contain a unauthorized physica 3/12/2024. There was no docummedical record of a C An interview with Resunable to be obtained. An interview was compm with the Activities Director reported she witnessed Resident # COVID test. The Activities Director obs Resident #15 on the I wheelchair. NA #1 pl back of Resident #15 resident's left arm with her body to immobiliz The Activities Director #1 to stop two times as	Additionally, the care plan atterventions related to entions which included opportunities for interaction were not any goals or nuated Resident #15 esident #15 was conducted by documentation of the I restraint by NA #1 on entation in Resident #15's coVID test being collected. Sident #15's family was ducted on 3/20/2024 at 4:13 Director. The Activities worked on 3/12/2024 and cover the cover of the cov		604	 Any Nurses, CNAs or Mas who han not went through the training prior to the compliance date will have to do so prior working again. Any Agency staff will be educated prior to working 4. How the corrective action(s) will be monitored to ensure the practice will not recur: The ADON, Social Services Direct Regional Nurse and/or DON, beginnin 4/18/2024, will conduct an audit of all residents weekly for 12 consecutive weeks. The audit will be done to ensure that all residents are free from any type unauthorized restraint. Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the Administrator as appropria The Audit findings will be reported the Administrator in a Monthly QAPI meeting for a minimum of 3 months. 5. The administrator is responsible for the execution for this plan with a compliance date of 4/24/2024 	e e of y by	
	and inserted the COV nostril. NA #1 told the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/2//2024
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	reported that she ferestraining her which verbalized she was witnessed the unaut. The Activities Direct ADON and Unit Mar 3/12/2024 and no a reported the incident (DON) on 3/12/2024 been handled.' An interview was composed the incident had test facility had administ residents once a were reported the facility outbreak as of 3/12/administered COVII facility and had no put that NA #1 assisted testing in the facility reported only Resident with the ADON. The facility reported only Resident with the facility reported only Resident with the facility resident #15 was sto take the COVID that Resident #15 was s	The Activities Director It as though NA #1 'was h is a form of abuse.' She the only staff member that thorized physical restraint. for reported the incident to the mager immediately on ction was taken. She also at to the Director of Nursing 4 and was told that 'it had anducted on 3/20/2024 at 3:25 She reported that after the sted positive for COVID, the ered COVID tests to all sek, on Tuesdays. The ADON had just gotten over a COVID	F6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZI 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	P CODE	
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F 604	She reported that on up Resident #15's no started screaming ar reported that once R her arms, she held h #1 stated after Resid test that she took her arms of Resident revealed no assessing 3/12/2024 after the unrestraint. An interview was composed with the DON. To made aware of Resident test by the ADON. To Director came to her aggravated that NA # the activity room to good did not recall the Activity room to good not recall the Activity had physically restrashe could have. The was being physically that she would go chear and interview was con Administrator on 3/20. Administrator was not being physically restrattempted to administrator was good and the Administrator was not being physically restrattempted to administrator was jeopardy on 3/20/2020. The facility provided	that she was going to do. It is she tried to put the swab It is she tried to put the swanding It is she tried to put the swanding It is medical record It is medical the Activities It is not it is medical It is medical the Activities in It is a covid test. The DON It is not that NA #1 It is shown if is member It is member	F6	504		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	,	00/21/2024
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	Continued From pa	ge 82	F 6	04		
	•	cipients who have suffered, or a serious adverse outcome compliance:				
		following actions to address vent any additional residents dverse outcome.				
	administering a CO #1 was observed by standing over Resid NA #1 stood on the wheelchair and wraback of Resident #7 resident's left arm a immobilize Resident was flailing and say test. The Activity D and NA #1 would no stick the swab up the	se aide (NA) #1 was VID test to Resident #15. NA y the Activities Director dent #15 in her wheelchair. right-hand side of her pped her left arm around the 15's neck and held down the and NA #1 used her body to tt #15's right arm while she ring that she did want a COVID irector tried to intervene twice, of stop. NA #1 proceeded to the resident's nostril to To test. Resident #15 (BIMS 4)				
	was discharged to the related issue and had a weekly skin at that showed no bruth that showed no bruth approximately 6:45. Unauthorized restrates authorization from the Party. NA #1 denied resident and never residents nostril beauthorization should be terminated as of 3/2 Operations and Residents.	the hospital on 3/16/24 for a Glass not returned. Resident #15 assessment done on 3/13/24 ising or skin issues noted. NA e DON on 3/20/22 at pm and educated on aint and ensuring that no trained without proper he Physician and Responsible as that she ever restrained the stuck the swab in the cause she refused. NA#1 was 20/24. The VP of Regional gional Nurse on 3/20/24 ints and determined that no				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OMMUNITY HEALTH C	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	00/2//2024
(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 COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 604	Regional Operation BIMS above 8 if the against their will. A have not been restreated to be a process or system from the action will adverse outcome from the action will the facility took the an adverse outcome (Completion Date: 3 - The facility's polici "Identifying Involunt Unauthorized Restrand Exploitation" poat approximately 6: Administrator, Social Nurse Consultant, For Clinical. The VP participants on the I Seclusion and Unauthe Abuse, Neglect importance ensuring from Restraints and - Current medication and CNAs will receil Involuntary Seclusion policy and the Abuse policy and the importance approximately 7pm.	Worker, MDS Nurse and s questioned all residents with by have ever been restrained ll residents stated that they ained. In the entity will take to alter the failure to prevent a serious om occurring or recurring, and be complete: following actions to prevent e from reoccurring. 8/22/24) es and procedures on ary Seclusion and aint" and the "Abuse, Neglect blicy were reviewed on 3/20/24 flopm by the DON, all Worker, ADON/IP, Regional Regional Operations, and VP of Clinical in-serviced the dentifying Involuntary athorized Restraint policy and and Exploitation policy and g all residents are kept free	F	504		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION		OATE SURVEY OMPLETED
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F 604	This education was approximately 7 pm Assistant Director of Nurse. Effective 3/2 CNA or licensed nurse gone through the ininclude an agency at Nursing will be responsed from the include an agency at Nursing will be responsed from the include and agency at Nursing will be responsed from the include the Includent of the Includent of Unauthorized Restricted Resident #1 the incident of Unauthorized Resident #1 the incident for Unauthorized Re	cal or Psychosocial harm. started on 3/20/24 at by the Director of Nursing, f Nursing and/or Regional 0/24 no medication aide, RN, rse will work without having -service training. This will and new staff. The Director of onsible for keeping up the list pletion. The Medical Director be Director of Nursing services mediate Jeopardy related to aint. The Medical Director ations. On 3/20/24 the DON 5's responsible party about atthorized Restraint. He voiced denied having any concerns.	F	504		
	completed the educ with the staff reveal education on the top On 03/20/24 the fact identifying involuntar restraints was revie	ation for all staff and interview ed that they had been pic. illities policy and procedure on ry seclusion and unauthorized				

		` '	SURVEY PLETED		
	345191 B. WI	ING		l	C 27/2024
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SURRY COMMUNITY HEALTH CENTER BY HARE	BORVIEW		MOUNT AIRY, NC 27030		
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F 604 Continued From page 85		F 604	1		
Nurse Consultant, Regional Operat clinical. On 03/20/24 the resident reparty about the incident of involuntary the representative voiced understate expressed no further concerns. On training was started with the adminiby the VP of Clinical services on did abuse, abuse investigation, and progresidents from abuse. Nursing staff and other department interviews residents from abuse. Nursing staff and other department interviews residents from care areas and to residents from care areas and to resident experience involuntary secusion. Residents were assessed no harm had completed the training on seclusion. Residents were assessed no harm had come to any resident. With the Medical Director revealed to concerns about the situation and the were not harmed. Administrative somewhat the situation and the were not harmed. Administrative somewhat the Medication Aid with during investigation and the Nursing was terminated. The IJ removal date of 3/22/24 was Develop/Implement Abuse/Neglect CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop implement written policies and process.	esponsible ary seclusion. anding and a 3/21/24 distration staff ferent types of otecting all ff interviews vealed they ang Involuntary on was and ag separation ensure no clusion. No o work until involuntary ed to ensure Interviews ane had no at residents staff interviews ducation for all staff, and Nurse vas suspended ag assistant e validated. Policies p and dedures that: abuse, ts and	F 607			4/24/24

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		PLETED
		345191	B. WING _			1	C 27/2024
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F 607	Continued From pag	ge 86	F	307			
	§483.12(b)(2) Estab to investigate any su	lish policies and procedures ach allegations, and					
	§483.12(b)(3) Includ paragraph §483.95,	e training as required at					
	§483.12(b)(4) Estab QAPI program requi	lish coordination with the red under §483.75.					
	occurring in federally facilities in accordan Act. The policies an	e reporting of crimes y-funded long-term care ce with section 1150B of the d procedures must include the following elements.					
		sting a conspicuous notice of defined at section 1150B(d)					
	retaliation, as define (2) of the Act.	ohibiting and preventing d at section 1150B(d)(1) and					
	facility failed to imple and exploitation poli- reporting, and invest actions perpetrated 3/10/24 Medication / (NA) #2 placed Resi in involuntary seclus Aide (NA) #1 utilized Resident #15 that waresident's medical sy incidents, MA #1 and continue working dir	view and staff interviews the ement their abuse, neglect, cy in the areas of protection, tigating allegations of abusive by staff toward residents. On Aide (MA) #1 and Nurse Aide dent #98 and Resident #305 ion and on 3/12/24 Nurse I a physical restraint for as not required to treat the ymptoms. Following the d NA #1 were allowed to ect care resident onally, the facility failed to			Immediate action(s) taken for the resident(s) found to have been affected include: Resident #15 had a weekly skin assessment done on 3/13/24 that shown to bruising or skin issues noted. NA # was called by the DON on 3/20/22 at approximately 6:45pm and educated of Unauthorized restraint and ensuring the no resident is ever restrained without proper authorization from the Physicial and Responsible Party. NA#1 was terminated as of 3/20/24. The VP of	wed t1 n at	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SO COMPL						
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F 607	Continued From pag	ge 87	F 6	307			
	investigate the alleg	ations and to report the			Regional Operations and Regional Nur	se	
		ate agency, law enforcement,			on 3/20/24 assessed all residents and		
		Services. The deficient			determined that no resident has an		
		ed for 3 of 3 residents			unauthorized restraint. On 3/20/24 the		
	•	and placed other residents at			Social Worker, MDS Nurse and Region		
		serious injury or harm			Operations questioned all residents wit		
		dent #98 and Resident #305).			BIMS above 8 if they have ever been		
	,	,			restrained against their will. All resider	nts	
	Immediate jeopardy	began on 3/10/2024 when			stated that they have not been restrain		
	MA #1 continued to	provide resident care			A visual inspection by the Director of		
	following an allegation	on of the involuntary			Nursing on 4/18/24 of all residents		
	seclusion of Resider	nt #98 and Resident #305.			determined that there were no resident	s in	
	Immediate jeopardy	was removed on 3/22/2024			any form of unauthorized restraint.		
	when the facility imp	lemented a credible					
	allegation of immedi	ate jeopardy removal. The			Resident #98 (BIMS 15) had a skilled		
	facility will remain ou	ut of compliance at a lower			assessment performed on 3/11/24 and		
	scope and severity	of "E" (no actual harm with a			found no behaviors at the time and she	,	
		harm that is not immediate			was also assessed by Geri psych NP		
		education is completed and			provider on 3/11/24 assessed and		
	monitoring systems	put into place are effective.			evaluated. She was discharged to		
					hospice house on 3/17/24. Resident #		
	Findings included:				had a skilled assessment performed by	1	
					nurse on 3/11/24 that revealed no		
		ty's "Abuse, Neglect, and			behaviors at the time and was assesse	d	
		mplemented on 3/1/2022			and evaluated by the Geri Psych NP		
	_	ged Violations, Crime,			provider on 3/11/24. Resident #305		
		se, Exploitation, Involuntary			(BIMS 9) was assessed by the DON or		
		buse, Misappropriation of			3/20/24 and the residents stated that s		
		Mistreatment, Neglect,			was not upset in any way from being in		
	•	ious Bodily Injury, Sexual			the activities room with Resident #98 o		
		e. The policy further revealed,			the night in question. She does not fee	21	
		s should be reported to the			like she was abused, neglected or	~	
		agency, adult protective			secluded in any way and is not showing	•	
		other required agencies (e.g.			any signs or symptoms of psychosocia problems. Medication Aide #1 was cal		
		nen applicable within s immediately, but not later			·		
	· •	e allegation is made, if the			by the DON on 3/20/22 at approximate	ıy	
		e allegation involve abuse or			4pm and educated on involuntary seclusion and ensuring that no residen	t ic	
		ily injury." The policy further			ever involuntarily secluded. MA#1 was		

			TIPLE CONSTRUCTION (X3) DATE COMP		LETED
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IUST BE PRECEDED BY FULL	ID PREFIX TAG	x	•		(X5) COMPLETION DATE
vestigation is warranted e, neglect or exploitation, glect, or exploitation occur. nvestigations include ible for the investigation, ndling evidence that could vestigation, investigating d violations, identifying blved persons, focusing ermining if abuse, neglect, , the extent, and cause; and thorough vestigation. The facility ure all residents are and psychosocial harm, use, during and after the mitted to the facility on acted on 3/20/2024 at 4:13 frector. The Activities orked on 3/12/2024 when empting to administer a ent #15 was flailing her activities Director over Resident #15 on the theelchair. NA #1 placed back of Resident #15's a resident's left arm with each her body to immobilize and. The Activities Director NA #1 to stop two times and and kept going. The ted that she felt as though	F	607	suspended pending investigation as of 3/20/24. The DON on 3/20/24 assesses the entire building and determined that resident was being involuntarily seclude On 3/20/24 the Social Worker began questioning all residents with a BIMS above 8 about if they feel like they have ever been secluded or isolated by the staff. All of the residents stated that the have never experienced involuntary seclusion. All residents were visually inspected on 4/18/24 by the Director of Nursing and none were found to be in a type of involuntary Seclusion. Identification of other residents having potential to be affected was accomplish by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence include: Current medication aides, RNs, license nurses and CNAs received training on Identifying Involuntary Seclusion and Unauthorized Restraint policy and the Abuse, Neglect, and Exploitation policy which outlines types of abuse and reporting responsibilities and procedure to follow. Inservice began on 3/20/24. This education was started on 3/20/24.	no ed. e ey any the ned d the	
	ER BY HARBORVIEW EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) 88 Vestigation is warranted be, neglect or exploitation, cocur. Investigations include sible for the investigation, indling evidence that could vestigation, investigating diviolations, identifying blived persons, focusing ermining if abuse, neglect, in the extent, and cause; and thorough vestigation. The facility ure all residents are and psychosocial harm, use, during and after the Inditted to the facility on Interest on 3/12/2024 when tempting to administer a tent #15 was flailing her the Activities Director over Resident #15 on the wheelchair. NA #1 placed back of Resident #15's the resident's left arm with the ded her body to immobilize and. The Activities Director NA #1 to stop two times that that she felt as though ther which is a form of birector immediately	ER BY HARBORVIEW EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) B8 EVESTIGATION INFORMATION B9 EVESTIGATION EVESTIGATION B9 EVESTIGATION B9 EVESTIGATION B9 EVESTIGATION B1 EVESTICATION B1 EVESTIGATION B1 EVESTIGATION B1 EVESTIGATION B1 EVESTIGATION B1 EVESTIGATION B1 EVESTIGATION B1 EVESTICATION B1 EVES	ER BY HARBORVIEW EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) B8 Vestigation is warranted e, neglect or exploitation, glect, or exploitation occur. nvestigations include sible for the investigation, andling evidence that could vestigation, investigating do violations, identifying olived persons, focusing ermining if abuse, neglect, t, the extent, and cause; and thorough vestigation. The facility ure all residents are and psychosocial harm, use, during and after the Imitted to the facility on Indicated on 3/20/2024 at 4:13 irrector. The Activities orked on 3/12/2024 when tempting to administer a lent #15 was flailing her exactivities Director over Resident #15 on the wheelchair. NA #1 placed back of Resident #15's exercisident's left arm with each produce the control of the	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030 EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL. TAG TOENTIFYING INFORMATION) 18 F 607 Suspended pending investigation as of 3/20/24. The DON on 3/20/24 assesses the entire building and determined that resident was being involuntarily seclude On 3/20/24 the Social Worker began questioning all residents with a BIMS above 8 about if they feel like they have ever been secluded or isolated by the staff. All of the residents stated that the have never experienced involuntary seclusion. All residents were visually inspected on 4/18/24 by the Director of Nursing and none were found to be in a type of involuntary Seclusion. The facility on a sidentify and administer a lent #15 was flailing her excitorion. The Activities Director over Resident #15 on the heelchair. NA #1 placed back of Resident #15's e resident's left arm with each er body to immobilize and care the body to immobilize and care the back of Resident #15's e resident's left arm with each er body to immobilize and the b	STREET ADDRESS, CITY, STATE, ZIP CODE ### STATE ADDRESS, CITY, STATE, Z

AND DI AN OF CORRECTION I DENTIFICATION NI IMBER-		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 607	Continued From page	e 89	F 6	307			
	ADON and Unit Mana taken at that time. Sh Nursing (DON) on 3/1	nister a COVID test to the ager and no action was e was told by the Director of 12/2024 that it had been as Director reported NA #1 incident.			Both occurrences were reported to the state on 3/20/24. On 3/21/24 the Administrator implement a new abuse investigation checklist that she will follow and complete to ensure	nted	
	Resident #15's medic	al record was reviewed and e of the abuse allegation /24 in the medical record.			investigations were initiated and completed thoroughly. On 3/21/24 the Administrator, DON, ADON, Activities Director, and Social		
	NA #1 worked on 3/13	, 3/18/2024, and 3/19/2024,			Services Director received education for the VP of Clinical on identifying different types of abuse/ the seriousness of allegations, timely and thorough abuse investigations and the importance of	nt	
	pm with the Assistant (ADON). The ADON i been cleared from a 0	reported the facility had just COVID outbreak and had			implementing protection for all resident and assessing all residents after allegations of abuse are made.		
	Tuesdays. She report the last round of COV	tests every week, usually on ted that NA #1 assisted with ID testing in the facility on N reported Resident #15 had		No resident, regardless of the situation, will be placed in any type of involuntary seclusion or unauthorized restraint.			
	Resident #15 outside administer the COVIE swatting at NA #1 and test. She reported she NA #1 had physically administer a COVID t	s aware NA #1 had taken of the activity room to 0 test, Resident #15 was d refused to take the COVID e was not made aware that restrained Resident #15 to est. ducted on 3/20/2024 at 5:20 e DON reported she was			All Nurses, CNAs and Medications Aid (MAs) will be reeducated starting 4/18/by DON, ADON, VP of Clinical, Administrator, Unit Manager and/or Regional Nurse on the Identifying Involuntary Seclusion and Unauthorize Restraint policy and the Abuse, Neglec and Exploitation policy which outlines types of abuse and reporting responsibilities and procedures to follo	ed et, w.	
	refusing a COVID tes stated the Activities D	t on 3/12/2024. The DON irector came to her on ggravated that NA #1 had			serviced on these items and policies during the orientation process by the D or ADON.		

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI COMPLET A. BUILDING						
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F 607	DON did not recall the describing how NA #1 that the Activities Dire and she just forgot. Twas allowed to work a a verbal write up for be department head (the DON reported no othe completed regarding restraint. The DON vebeing physically restrashe would go check of the incident, suspend the incident, suspend the incident. The DON who she would report she did not feel that the reported because she Director telling her Rephysically restrained. An interview was condadministrator on 3/20 Administrator was not being physically restratempted to administ verbalized the incider investigated and repoen forcement, the state corporate office. 2. Resident #98 was a 2/15/24 with diagnosed dementia with agitatic disorder, disorder of a behavior, hemiplegia cerebral infarction (state)	o give a COVID test. The exactivities Director administered the test, but ector could have told her, the DON reported NA #1 after 3/12/2024 and received being insubordinate to a exactivities Director). The er investigation was the unauthorized physical exhalized if a resident was ained by a staff member, on the resident, investigate the employee, and report in did not specifically indicate the incident to. She stated his incident needed to be a did not recall the Activities exident #15 had been adducted with the exact which includes the incident to. She stated has exident #15 had been adducted with the exact which includes the incident was exident #15 ained by NA #1 while NA #1 are a COVID test. She at should have been exident to local law agency, and the facility on the exact which included severe on, bipolar disorder, anxiety adult personality and and hemiparesis following	F	607	Any Nurses, CNAs or Mas who has not went through the training prior to the compliance date will have to do so prio working again. Any Agency staff will be educated prior working. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 4/18/24 The ADON, Regional Nurse and/or DON will conduct an audi all accusations of abuse weekly for 12 consecutive weeks. The audit will be do to ensure that all accusations of abuse are reported and investigated per policity and the checklist is completed. Any deficient practice found during the audits will be corrected immediately an education and/or corrective action done by the Administrator as appropriate. The Audit findings will be reported by the Administrator in a Monthly QAPI meeting for a minimum of 3 months. 5. The Administrator is responsible for the execution of this plan of correction with a compliance date of 4/24/2024.	to to to ti al it of one y de	
	3/17/24.	-					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	03/2//2024
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F 607	Continued From pa	ge 91	F6	507		
		admitted to the facility on es including dementia and				
	AM with Nurse #3. Ithe night of 3/10/24 Nurse #3 said she was who resided on B has Resident #305 who as familiar with Resignation in the side of the s	erformed on 3/20/24 at 7:05 She stated she had worked (7:00 PM- 7:00 AM) on A hall. vas familiar with Resident #98 all. She said she also knew resided on B hall but was not ident #305 because she had a few days ago. She stated, creaming/ yelling behaviors d at night. Nurse #3 stated, no isolated her [Resident ntified the "girl" as Medication ned she remembered the ght of 3/10/24. She stated she in A hall the night of 3/10/24 a #1 had been working on B d she heard a resident he had gone to see about the nd found Resident #98 and dining room alone, with If the doors closed, and creaming/yelling loudly. Nurse emoved Resident #98 from som, she was uncertain of the d it was between 8:00 PM- ained she was taking Resident m on B hall when Medication in and said, "She can't come kept everyone up for three come down here." Nurse #3 Medication Aide, "Yes she can, Jurse #3 said Nursing ook Resident #98 to her room and the resident quieted				

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION			, ,	(3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		13/21/2024
			542 ALLRED MILL ROAD		
SURRY COMMUNITY HEALTH CENTE	R BY HARBORVIEW		MOUNT AIRY, NC 27030		
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F 607 Continued From page 93	2	F 6	07		
down. She verbalized Noremoved Resident #305 took her back to her room was unsure how long Ref #305 were in the activity had been "at least an how there was not anyone from facility during the night, sincident during 7:00 AM Medication Aide #5 the ferom (3/11/24). She said she amessage to the Assistant (ADON) on 3/11/24 to reflect the first time should be a stated her phone indicated been delivered but she reflect the ADON. Nurse #3 stated her phone indicated been delivered but she reflect the ADON. Nurse #3 stated had continued to work on 3/13/24 Medical and had continued to work on 3/13/24 Medical and had continued to work on Bh "felt like the Medication American Amer	A #2 then went and from the dining room and m. Nurse #3 said she esident #98 and Resident /dining room but stated it ur." Nurse #3 explained, om administration at the so she reported the shift change report to collowing morning also sent a phone text at Director of Nursing port the incident, she did to esent the message. She ted the message had never heard back from ted no one from the coask about the incident atted when she returned to the tion Aide #1 was working ork at the facility since. The incident atted when she returned to the incident atted when she returned to the incident atted when she returned to the incident was typically all. Nurse #3 stated she incide #1 was typically all. Nurse #3 stated she incident #98 and Resident the incident was abuse. In Nurse #3 was 19:22 AM and revealed acility since January 2023 and not provided any abuse in working at the facility.	F 6			

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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F 607	report concerns of ab unsure if Medication A care for Resident #98 of the shift on 3/10/24 #1 had been assigned #3 stated Medication the facility since the in 3/10/24. A telephone interview Medication Aide #5 of explained she received report on the morning who had worked nighth stated Nurse #3 had the report that Medication #98 and Resident #36 with the doors closed continued to explain the had been screaming taken Resident #98 bear Aide #1 stated, "Don'th the residents are tired Medication Aide #5 streported the incident. Nursing (ADON) on the further explained, Nursent a phone text medication to report the incident, "Tafter the incident occurs about the incident had bother ead the definitions the abuse was." The Medication Aide #5 streported the incident occurs about the incident occurs about the incident occurs about the incident had bother ead the definitions the abuse was." The Medication The Medication Streported the incident had bother ead the definitions the abuse was." The Medication The Medication Streported the definitions the abuse was." The Medication The Medication Streported the definitions the abuse was." The Medication The Medication The Medication Streported the definitions the abuse was." The Medication The Medi	eporting or who she should use to. She stated she was Aide #1 had continued to and #305 for the remainder by but that Medication Aide do to work on B hall. Nurse Aide #1 continued to work at incident that occurred on was performed with a 3/20/24 at 3:40 PM. She aid (7:00 AM) shift change of 3/11/24 from Nurse #3 to shift on 3/10/24. She atold her during shift change of Aide #1 had put Resident D5 in the activity/dining room and Medication Aide #5 Nurse #3 said Resident #98 loudly and when she had ack to B hall, Medication to the process of the street of the street was a street was	F	607			

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		33/2/1/2024	
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F 607	at 9:37 AM with Meworking at the facilit She stated, on 3/10. Resident #98 and Resident part and resident #98 dark part and resident #98 and R	dication Aide #1, who was still by at the time of the interview. Was around 8:00 PM she put resident #305, who had also the activity/dining room they were yelling/screaming the residents on the hall from the two residents were in the sut an hour, she did not say along the residents had been in the explained while the two the activity/dining room she had reaming at each other and the ad gotten louder when the discreaming at each other. Who was working on A hall, the residents needed to be the ded she had put the residents around for the other residents around for the lights in the the were originally on, but then at for the light from the suspended or that the teal had been open. She did the suspended or that the teal had been working and ball the night of 3/10/24. Medication Aide #1 had put	F 60	77			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		NSTRUCTION	(X3) DATE COMP	SURVEY LETED
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F 607	already been on and off" (wall sconces) ha activity/dining room. door to the activity/din B hall was originally or remained open. She stated she had from the facility incident or if she had from the facility. On 3/22/24 at 10:00 A performed with the All incident of Resident # being placed in the activity and performed with the All incident of Resident # being placed in the activity and time the incident She stated she had in Nurse #3 reporting the Medication Aide #1 a intervention to put the room to socialize." The had been an appropriate of Nursing (DON) on what time she had reported of Nursing (DON) on what time she had reported of Nursing (DON) on what time she had reported of Nursing (DON) she stated been suspended that incident was investigated seen the incident	that the "lights that don't go d been on in the She explained the wooden ning room that connected to open, but she was unsure if it stated the residents were in roout 45 minutes, but she how long. She did not had contacted her about the received abuse training AM an interview was DON. She stated the #305 and Resident #98	F	607			
		frequent checks, and the ning room was open.					

	OF DEFICIENCIES CORRECTION	RRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLE		ATE SURVEY OMPLETED		
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	00/21/2024
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 607	#98 and Resident # activity/dining room 3/10/24 by the ADC specify what time si not explain if Medic been suspended or investigated the inc it was okay that star who were having so into the activity/dinil lighting, and with th stated she felt this is staff had been trying Resident #305 with not think the intent and Resident #305, provide an activity t said she had not se residents being sec to provide documer investigation of the An interview was pe PM with the Admini was aware of the in Resident #98 and F placed in the activit not say when she h incident. The Admir was not reported to She verbalized floo incident and concer being secluded to th and they had "looke the floor staff had re administrative nursi	Director of Nursing (DON). Ire of the incident, Resident 305 being placed in the by staff, that occurred on N on 3/11/24, she did not he was made aware. She did ation Aide #1 or NA #2 had how the facility had ident. She stated she had felt if had placed both residents, creaming/ yelling behaviors, hig room alone, with dim he doors closed. The DON had been appropriate because g to provide Resident #98 and han activity. She stated she did was to isolate Resident #98 he she stated, "I think it was to help with behaviors." She hen the incident as the luded. The DON was not able htation about the facility	F	507		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X*)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING		,	C 3/27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		312112024	
(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 607	Continued From page 97 had been "looked at." She did not mention if						
	Medication Aide #1 h stated the facility had seclusion and said th	nad been suspended. She d not seen the incident as ne door was open and people esident #98 and Resident					
		n Aide #1's time record 3 3/10/24, 3/13/24, and					
		time record revealed she had 1/24, 3/12/24, 3/14/24, I.					
	incident. The facility	ole to provide any rding an investigation into the did not have any facility ecords for the month of					
	The Administrator wa jeopardy on 3/21/202	as notified of immediate 24 at 9:35 am.					
		the following credible ate jeopardy removal:					
	are likely to suffer, a because of the nonc	following actions to address ent any additional residents					
	Nurse Aide (NA) #1 #15 to obtain a COV Director reported her	ctivities Director observed physically restrain Resident ID test. The Activities r observation to the Assistant ADON), Unit Manager, and					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345191	B. WING			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	ODE	33/21/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 607	investigation comple Resident #15 after It The facility failed to NA #1 to continue weekly skin assess showed no bruising was called by the Dapproximately 6:45 Unauthorized restratesident is ever restauthorization from the Party. NA#1 was to VP of Regional Operation 3/20/24 assesses that no resident has On 3/20/24 the Soc Regional Operation BIMS above 8 if the against their will. A have not been restrated were placed in an amedication Aide (Mand recess lighting were lit which proving Resident #98 and It no staff supervision	ing (DON). There was no eted and no assessment of peing physically restrained. protect residents by allowing vorking. Resident #15 had a ment done on 3/13/24 that or skin issues noted. NA #1 ON on 3/20/22 at per and educated on int and ensuring that no rained without proper the Physician and Responsible terminated as of 3/20/24. The erations and Regional Nurse d all residents and determined an unauthorized restraint. Find Worker, MDS Nurse and se questioned all residents with y have ever been restrained li residents stated that they	F	607	Y)	
	the room due to scr which disturbed oth 200 hall. There was involuntary seclusio Resident #305 and #98 and Resident # the facility after invo- failed to protect resi	eaming and yelling behaviors er residents trying to sleep on s no investigation following the n of Resident #98 and no assessment of Resident 305 or any other residents in pluntary seclusion. The facility dents by allowing MA #1 to Resident #98 (BIMS 15) had a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C	
	ROVIDER OR SUPPLIER	CENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		<u>13/27/2024</u>	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	found no behavior assessed by Geri assessed and eva hospice house on skilled assessmer 3/11/24 that revea and was assessed Psych NP provide (BIMS 9) was ass and the residents any way from beir Resident #98 on the notificial feel like she was ecluded in any way or symptoms of psecure may be determined the suspended pendir The DON on 3/20 and determined the involuntarily section worker began que BIMS above 8 above the residents state experienced involuntarily section of the policy of the policy of the action was process or system adverse outcome when the action was the facility took the facility's policy of the p	at the time and she was also psych NP provider on 3/11/24 aluated. She was discharged to 3/17/24. Resident #305 had a performed by nurse on aled no behaviors at the time d and evaluated by the Geri r on 3/11/24. Resident #305 essed by the DON on 3/20/24 stated that she was not upset in ag in the activities room with the night in question. She does as abused, neglected, or any and is not showing any signs sychosocial problems. If was called by the DON on imately 4pm and educated on ion and ensuring that no voluntarily secluded. MA#1 was ang investigation as of 3/20/24. If they feel like they have end or isolated by the staff. All end that they have never untary seclusion. The entity will take to alter the a failure to prevent a serious from occurring or recurring, and	F	507			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRU NG			SURVEY PLETED
		345191	B. WING _			1	C 27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		542 ALLREI	DRESS, CITY, STATE, ZIP CODE D MILL ROAD RY, NC 27030	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E PROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 607	and Exploitation" poli at approximately 6:15 Administrator, Social Nurse Consultant, Re of Clinical. The VP o participants on the Id Seclusion and Unaut the Abuse, Neglect a outlines types of abuse responsibilities and p Current medication a and CNAs will received Involuntary Seclusion policy and the Abuse policy which outlines responsibilities and p Inservice began on 3 7pm. This education approximately 7 pm to Assistant Director of Nurse. Effective 3/20 CNA, or licensed nursing one through the in-sinclude agency staff of Nursing will be resulted in the staff training composition of the staff training composit	nt" and the "Abuse, Neglect by were reviewed on 3/20/24 sipm by the DON, Worker, ADON/IP, Regional egional Operations, and VP of Clinical in-serviced the entifying Involuntary morized Restraint policy and and Exploitation policy which se and reporting rocedures to follow. Ides, RNs, licensed nurses, extraining on the Identifying and Unauthorized Restraint, Neglect, and Exploitation types of abuse and reporting rocedures to follow. Ides, RNs, licensed nurses, extraining on the Identifying and Unauthorized Restraint, Neglect, and Exploitation types of abuse and reporting rocedures to follow. Idea of the identifying and Unauthorized Restraint, Neglect, and Exploitation types of abuse and reporting rocedures to follow. Idea of the identifying and Unauthorized Restraint to the Director of Nursing, Nursing and/or Regional of the Director of Nursing and/or Regional of the William of the State on the Idea of Idea of the Idea of Idea	F	607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345191	B. WING_			C 03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	03/2//2024	
				542 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		D 4.T.E.	N
F 607	Continued From page	e 101	F 6	607			
	received education fr identifying different ty seriousness of allega abuse investigations, implementing protect	om the VP of Clinical on					
	Administrator on 3/21 restraint allegations to deny that these alleg them. The Activities surveyors that she di abuse to both the Adwere no witnesses to statements. All involvelated to Abuse, rep	estioned the DON and /24 about the unauthorized being reported to them. Both ations were reported to Director stated to the director report the allegations of ministrator and DON. There corroborate any of these wed received reeducation orting, investigations, and abuse from the VP of Clinical					
	the incident where re placed in the activity to MA#1 and another night and didn't feel li seclusion because of seclusion that include monitored separation be considered involuin permitted if used for a therapeutic interventi professional staff can meet the resident's ni restrictive approach i amount of time". The related to Abuse, rep	ed that she was informed of sident #98 and #305 were room on 3/14/24 and spoke nurse that were present that ke it was involuntary the definition of Involuntary es "Emergency or short term from other residents will not intary seclusion and may be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 3/27/2024		
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		5/21/2024		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 607	On 03/26/24, the faremoval plan was vand interviews: The facility failed to seclusion and physifacility failed to prote to continue working physical restraint of the Administration of investigation was costaff. On 03/13/24 no injuries were ide restraint. On 03/20, completed by the Dunauthorized restraint every restraining an terminated from the On 03/20/24 the VF Regional Nurse assidetermined that no restraint. The social Regional Operation 03/20/24 and no resulterviews with staff received training on On 3/21/24 training administration staff on reporting differer staff interviews and revealed they had resulted to section of the	report suspected involuntary alidated through record review report suspected involuntary acal restraint of residents. The ect residents by allowing a NA after a suspected incident of a resident was reported to an 03/12/24 and no completed by the administration resident was assessed, and intified from the physical /24 individual training was ON with the NA on int and ensuring resident is indultimately the NA was position. Of Regional Operations and resident had unauthorized all worker, MDS Nurse and interviewed all resident on sident reported being restraint.	F6	07				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY	Y
					С	
		345191	B. WING _		03/27/202	24
	ROVIDER OR SUPPLIER OMMUNITY HEALTH CEI	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPI	X5) PLETION ATE
F 641 SS=B	completed the training seclusion. On 03/26/action plan for reportinvoluntary seclusion validated through recand audits and interview worked for the facility training on reporting lunauthorized restrain and Exploitation policabuse and reporting procedures to follow. Interviews revealed the education for reportinall staff employed by The IJ removal date of Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revifacility failed to accur. Minimum Data Set (Noresident reviewed for #103). The findings included Resident #103 was a 01/23/24. Facility docurrent resident was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24. Facility docurrent reviewed for Resident #103 was a 201/23/24.	n to work until they had g on reporting involuntary (24, the facility's corrective ing abuse, neglect, and , effective 03/23/24 was cord review of assessments iews with all staff who for the Nursing staff received involuntary seclusion, and the Abuse Neglect by which outlines types of responsibilities and Administrative staff iney had completed the ag involuntary seclusion for the facility. For 3/22/24 was validated inents of Assessments. Set accurately reflect the ately complete the discharge MDS) assessment for 1 of 1 hospitalization (Resident)	F6		set . A n ed	24

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345191	B. WING _			1	C 27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		542	REET ADDRESS, CITY, STATE, ZIP CODE 2 ALLRED MILL ROAD DUNT AIRY, NC 27030	1 001	21/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	O2/09/24 revealed the short-term general he short-term general he An interview was con Assessment Director 11:08 am, both of wh health record of Resi Assessment Director MDS assessments, t MDS/Resident Asses Resident #103 was discharged to the hos confirmed that Resid the community. MDS Director #1 stated the been coded for disch An interview with the was conducted on 03 DON stated the MDS discharge MDS assed did not know why the Resident #103 was considered and the short was considered to 100 DON stated the MDS discharge MDS assed did not know why the Resident #103 was considered to 100 DON stated the MDS discharge MDS assed did not know why the Resident #103 was considered to 11:08 am, both of the short was considered to 11:08 am, both of the sho	et103's discharge MDS dated et discharge status was to a ospital (acute hospital). Inpleted with MDS/Resident is #1 and #2 on 03/19/24 at om reviewed the electronic dent #103. MDS/Resident if the stated she reviewed the inen signed them. Is sment Director #2 reported ocumented in MDS as being spital; however, she ent #103 was discharged to if the MDS should have arge to the community. Director of Nursing (DON) If 22/24 at 10:40 am. The inverse completed the inense sements. She reported she discharge assessment for oded in error; but, stated in a "mis-click" when entering	F	641	2. Identification of other residents have the potential to be affected was accomplished by: " All residents who discharge have the potential to be affected by this deficient practice. The MDS nurses #1 and #2 completed a 100% audit of the of discharged residents for the last three months to ensure coding accuracy of discharge location and found no further issues on 3/19/2024. 3. Actions taken/systems put into plate to reduce the risk of future occurrence include: " Education was provided to MDS nurses #1 and #2 on discharge coding accuracy by the regional MDS consultation 3/19/2024 using the RAI manual on Section A PASRR coding. " This education will be provided to new MDS hires by the Lead MDS nurses. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: " The MDS Coordinators and/or Regional MDS, beginning 4/18/2024, conduct an audit of all resident dischard MDS coding once per week for 12 week to determine if the discharge was code accurately. " Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the DON as appropriate. " The Audit findings will be reported the DON in a Monthly QAPI meeting for	the t r ce ant any e. e ot will ge .ks d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345191	B. WING _		C 03/27/2024
	ROVIDER OR SUPPLIER	CENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 641	Continued From pa	age 105 d for Dependent Residents	F 6	minimum of 3 months. 5. The administrator is response execution of this plan with a compliance date of 4/24.	
SS=E	S483.24(a)(2) A re out activities of da services to mainta personal and oral This REQUIREME by: Based on observation and staff interview baths and showers residents requiring assistance with activities was for 3 of 8 (Residents #59, #3). The findings included 1. Resident #59 was chronic obstructive and a need for assistance with activities and a need for assistance personal hygiene in impairments. Revieplan did not included fassistance with	esident who is unable to carry sily living receives the necessary in good nutrition, grooming, and hygiene; ENT is not met as evidenced ations, record review, resident is the facility failed to provide is, and incontinence care for it or dependent on staff attivities of daily living (ADL). It residents reviewed for ADLs is and #4). Ided: as admitted on 11/8/23 with it is pulmonary disease (COPD) is istance with personal care. care planned on 11/17/23 for it is with grooming, bathing and it related to mobility and self-care it is with grooming and it is refusals.		1. Immediate action(s) taken resident(s) found to have been include: " The facility failed to provid showers and incontinence care residents requiring or depende assistance for activities of daily # 59 and #305. Administrator in and assessed #4, #59 and #304/16/24 and found that shower been provided as scheduled an incontinence care was provided 2. Identification of other residence potential to be affected was accomplished by: " All incontinent residents and dependent on staff for ADL □s potential to be affected by this practice. 3. Actions taken/systems put to reduce the risk of future occinclude:	for the a affected le bath and e for ent on staff y living, # 4, interviewed 0.5 on is have and d timely. Idents having is and those have the deficient tinto place

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345191	B. WING				07/0004
NAME OF PI	ROVIDER OR SUPPLIER	0.0101			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	27/2024
				5	42 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW			MOUNT AIRY, NC 27030		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 677	Continued From pag	e 106	F	677			
	moderate assistance	with bathing and showering.			" The Director of Nursing, Assistant		
					DON, VP of Clinical, Regional Nurse		
	·	#59's bath documentation			and/or Unit manager, beginning		
	from 1/1/24 to 3/21/2	24 noted the following:			4/18/2024, will provide education to Nurses, Medication Aides and CNAs or	<u> </u>	
	*January 2024: docu	mented evidence of bed bath			the Activities of Daily Living policy and		
		9/24, 1/13/24, 1/16/24,			importance of ensuring that Showers,	uic	
		26/24 and 1/30/24. No			Incontinent care and all ADL care is		
		y showers was provided by			provided as needed for all residents.		
	the facility.				" All Nurses, Medication Aides and		
					CNAs will be in serviced on these item		
	•	umented evidence of bed			and policies during the orientation prod	ess	
		4, 2/9/24, 2/13/24, 2/16/24,			by the DON or ADON.		
	showers was provide	No documentation of any			" Any Nurses, Medication Aides or CNAs who have not went through the		
	Silowers was provide	ed by the facility.			training prior to the compliance date wi	Ш	
	*March 2024: docum	ented evidence of bed bath			have to do so prior to working again.	"	
	on 3/1/24 and 3/5/24	. No documentation of any			" Any Agency will be educated prior	to	
	showers was provide	•			working.		
	An observation was	completed on 3/21/24 at 9:40			4. How the corrective action(s) will be	e	
		as lying on top of his bed			monitored to ensure the practice will no		
	wearing a button up	shirt and a pair of shorts. He			recur:		
		I but he was absent of bodily			" The Regional Nurse, ADON and/o		
	odors.				Unit Manager, beginning 4/18/2024, w		
	Di	.::U- D:-11 #50 0/04/04			complete an audit of 3 random residen		
	_	with Resident #59 on 3/21/24 d he completed his own			per hall 5 times per week x 4 weeks the 3 x per week x 8 weeks to ensure that	en	
	· ·	occasion, one of the aides			incontinence care is being provided tim	nelv	
		et his bath items up but on			and provided showers as scheduled.	iciy	
		did not. Resident #59 stated			" Any deficient practice found during	ן נ	
		ing him any showers and had			the audits will be corrected immediately		
		ated he had not mentioned it			and education and/or corrective action	•	
	to anyone because h	ne liked it at the facility, and			done by the DON as appropriate.	ĺ	
	he did not want to ge	et "kicked out".			" The Audit findings will be reported	-	
	<u></u>				the DON in a Monthly QAPI meeting fo	ra	
		mpleted on 3/21/24 at 2:40			minimum of 3 months.		
	_	istant (NA) #5. She stated with Resident #59 and knew			5. The administrator is responsible for	the	
	Land Tournery Worker	with Nesident #33 allu Niew	1		TO THE AUTHINGUALULIS LESSONISHINE TO I	0.162	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C / 27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	stated he preferred by refuse any ADLs. She baths and only need him. NA #5 denied a would prevent her from assignments. An interview was comply with NA #6. She not go to the shower problem with spasmes afe for him. NA #6 doing his own bed by assistance. NA #6 dothat would prevent he assignments. A care observation with 10:10 AM with the Treatment Nurse and he had any problem spasms were observation with a bath yet to the last time he had months ago. During an interview of 3/22/24 at 10:20 AM explanation as to whe receiving his bed bat was her expectation.	rer per his request. NA #5 red baths and does not re stated he does his own s his bathwater set up for rny staffing concerns that rom completing her repleted on 3/21/24 at 2:45 restated Resident #59 could room because he had a s in his legs and it was not restated Resident #59 preferred retarts and only required set up renied any staffing concerns rer from completing her reas conducted on 3/22/24 at reatment Nurse and the	F 6	777	execution of this plan with a compliance date of 4/24/2024.	e		
	3.) Resident #4 was 6/22/23 with diagnos	admitted to the facility on es including muscle						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		IPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C 03/27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		E, ZIP CODE	03/2//2024	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 677	Continued From page	e 108	F 6	577			
	weakness, neuromus bladder, and the need personal care.	cular dysfunction of the d for assistance with					
	required staff assista and activities of daily interventions included incontinent episode, incontinence protection	22/23 revealed Resident #4 nce with personal hygiene living (ADL). The care plan d Incontinent care after each use of brief/pads for on, catheter care as needed, gh skin care after incontinent					
	was cognitively intact bowel, had an indwel substantial maximum toileting hygiene. The	et (MDS) quarterly /31/24 revealed Resident #4 She was incontinent of ling catheter, and required assistance by staff with MDS indicated her vision ad no rejection of care.					
	#4's room was perfor 12:50 PM. At 11:25 A	ous observation of Resident med from 11:25 AM through M the call light above as observed turned on from					
	3/17/24 at 11:33 AM observed in her room indwelling catheter produced bedside drainage bag her bed indicated her stated she had turned prior (around 11:00 A assistance. She verb movement and needed.	g. The call bell panel behind call bell was turned on. She her call bell on 30 minutes M) to call for staff alized she had a bowled staff to come change her.					
	At 11:36 AM Nurse A	ide #3 (NA) entered					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			1	27/2024	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY	Y, STATE, ZIP CODE	1 00/	2172024	
SURRY C	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW		542 ALLRED MILL ROA MOUNT AIRY, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	Continued From page	e 109	F 6	77				
	Resident #4's room, t exited the room.	urned off the call light, and						
	12:05 PM on 3/17/24 turned off her call light said she would come back to help her. She incontinence. Reside back on again. At 12:09 PM the Soci	sident #4 was performed at and revealed NA #3 had at. Resident #4 stated the NA back, but no one had come stated she still had bowel at turned her call light al Worker (SW) entered and turned off her call light.						
	The SW exited the ro An interview with the PM on 3/17/24 when	•						
	she was going to get	an NA to assist the t specify what type of						
	and staff started pass PM. Medication Aide room at 12:22 PM, N. behind the privacy cu bedside. At 12:23 PM entered the room and Resident #4. NA #3 a exited the room at 12 Admission Coordinate	th cart arrived on the hallway sing out meal trays at 12:20 #4 and NA #3 entered the A #3 was observed going rtain to Resident #4's If the Admission Coordinator If delivered a meal tray to and Medication Aide #4 both 1:24 PM. At 12:28 PM the for exited the room.						
	Coordinator at 12:28p exiting the room. The explained her role at Admission Coordinate	om on 3/17/24 upon her Admission Coordinator						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		03/21/2024	
(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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	help cut up her chic foul odor, or the resincontinence care. At 12:29 PM the As (ADON) entered Robserved going bel Resident #4's beds exited Resident #4' An interview was p 12:31pm on 3/17/2 #4's room. The ADordrink to Resident # odor, or the resider incontinent care The continuous observed many part of the continuous observed going below the second part of the continuous observed part of the continuous observed going going part of the continuous observed going	ad asked her for ice and to oken. She did not mention a sident needed assistance with sistant Director of Nursing esident #4's room. She was nind the privacy curtain to ide. At 12:31 PM the ADON s room. The formed with the ADON at 4 upon her exiting Resident ON stated she had given a 4. She did not mention a foul at needed assistance with servation of Resident #4's d from 12:31 PM to 12:50 PM; r staff members observed	F	<u>'</u>			
	performed with Res bed, with the head meal tray set up in table. She stated si incontinent care an bowel movement in told her "She was s soon after lunch as A follow up intervie Resident #4 on 3/1 she was clean and provide her bowel i She stated she kne	erview and observation were sident #4. She was observed in of her bed raised, with her front of her on the overbed taff had not provided d she still had incontinent a place. She stated NA #3 had corry and would get to her as she could". w was performed with 7/24 at 3:41 PM. She stated dry. She said NA #3 came to incontinence care at 2:00 PM. we the time was 2:00 PM booked at the clock and a family					

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		345191	B. WING _			C 03/27/2024	
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(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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	An interview was per PM with Medication should be checked incontinent care. Shi incontinent and had they should not have having one NA for 2 for the NA's to com and ADL care need a resident turned or and asked to be chartened by the hall yet, then staresident. She said it hall, it was more difficult have to sit in bowel one should have to that was "disgusting degrading for a resist soiled brief or bower She stated staff typ light without assisting needs. She said she had needed to be continued in the period of the	facility doing her hair. erformed on 3/17/24 at 4:23 Aide #4 She stated residents every two hours for the explained If a resident was a requested to be changed, the to wait. She explained with the residents it was impossible explete all the scheduled tasks as for the residents. She said if the real light at 11:30 AM anged, if trays were not out on aff would go in and change the fineal trays were out on the ficult with only one NA on the erficult with only one to eat. She said no sit in bowel movement to eat, gr. She verbalized it would be dent to have to sit in a wet of movement to eat their meal. In its light of the resident with their ere was not aware the resident	F6				
	NA #3 stated she w rounds for incontine	eas typically only able to do 3 ence care during her 7:00 NA #3 stated she did not go in					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	CODE	03/21/2024		
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 677	Resident #4 did have stated Resident #4 hrequesting incontinershe had answered the turned off the call light would be back but "gethought having to ear would make her and. An interview with the was performed on 3/stated staff should preson as possible. She incontinent care at a resident. She explain heavier and need incompared incompared in the staff try to make rour every 2-3 hours. She if staff could get to it what staffing was like not turn off a call light incontinent care. She be attended to and sexplained staff could care even if meal sets add if no one was ear go in the room and present in the staff of the staff could care even if meal sets and if no one was ear go in the room and present in the staff of the staff could care even if meal sets and if no one was ear go in the room and present in the staff of the staff o	#4 until 2:00 PM and that be bowel incontinence. She and turned on her call bell ince care before lunch, and he light. NA #3 said she had hit and told Resident #4 she got busy". She said she it sitting in bowel incontinence the resident feel terrible. Director of Nursing (DON) 21/24 at 4:15 PM. The DON rovide incontinence care as he stated staff provided frequency as needed per hed some residents urinate continent care more and for non-oriented residents, hads for incontinence care be explained she was not sure hat that frequency because of he. The DON said staff should hould not be passed. She he provide bowel incontinence roice was going on. The DON hating in the room, staff could hourovide bowel incontinence hering in control of yourself heel good. "	F	577				
	provide incontinence requested to. She sa the call light and not	she expected the staff to care when they were aid staff should not turn off come back. The she would not consider a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 677	being on the floor fro incontinent care to be manner. The Administ being within 10-15 m expect staff to check frequently throughou needs. When asked meant, the Administrexpand on that, and The Administrator state a meal in bowel incorresident not feel good	isode emergent as someone m a fall but would expect the exprovided in a timely strator explained timely as in. She said she would on non-oriented residents the shift for incontinent care to expand on what frequently ator stated she could not could not say every 2 hours. Atted a resident having to eat intinence would make the d. She said they would not imething that should have	F	577			
	3/6/24 with diagnose weakness, and the new personal care. A care plan dated 3/8 required staff assista and activities of daily dated 3/14/24 indicated alteration in elimination related to dementia, history of UTI's. The included staff assistated hygiene, Incontinent episode, use of brief, protections, and provafter incontinent episode. The Minimum Data Sassessment dated 3/#305 had moderately	B/24 revealed Resident #305 nce with personal hygiene living (ADL). A care plan red she was at risk for on of bowel and bladder functional incontinence, and care plan interventions nce with ADL's and personal care after each incontinent pads for incontinence riding thorough skin care odes.					

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODI 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	I	03/27/2024		
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F 677	on 3/17/24 at 11:30 interview were performed from 11:2 11:36 AM NA #3 entered for ESW exited the rop PM the lunch cart arbegan to pass out lu 12:20 PM. At 12:22 and NA #3 entered to Medication Aide #4 blood sugar at 12:25 Director of Nursing (they pulled Resident with the Admission Coord ADON entered or she was at the be provided meal tray intered to mean to pass out lu 12:20 PM. At 12:22 and NA #3 entered to Medication Aide #4 blood sugar at 12:25 Director of Nursing (they pulled Resident recovered the tray on R NA #3 was at the be provided meal tray in the Admission Coord ADON entered room	AM an observation and rmed with Resident #305. In the bed with her night gown on her back in the bed with oward the center of the bed. It, and able to answer #305's bottom sheet had a per her buttock and her top the touch. Resident #305. In the bed with oward the center of the bed. It, and able to answer #305's bottom sheet had a per her buttock and her top the touch. Resident #305. In the second was 12.50 PM. At the pred the room but did not 15. At 12:09 PM the Social of the room but was not the period of the room but was not the period on the hallway. Staff onch trays on the hallway at PM the Medication Aide #4	F6	577				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		33/21/2324	
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677		ge 115 e ADON exited the room at	F 6	577			
	pm on 3/17/24 when SW stated a couple she was going to go residents. She did r assistance the residents. She did r assistance the residents. She did r assistance the residents. An interview was performed as the stated she gave Renot mention any odd care needs for the resident she and of the bed raise cup of coffee, with the renot the overbed she was still wet. Since was going to complete the she was going to complete the s	erformed at 12:31pm on DON exited the room, she sident #305 insulin. She did or of incontinence or other esident. ion at 12:32 PM on 3/17/24 #305 was in her bed, with the sed, in her gown, holding a ner meal tray set up in front of table. Resident #305 stated ne stated, "that women said ome change me in a little bit". In 213 was continued from M and there were no other erved to enter the room. In and observation of Resident d on 3/17/24 at 3:39 PM. She her wheelchair, with a new made with new linen and a esident #305 stated she was erformed on 3/17/24 at 4:23 Aide #4 She stated residents					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/21/2024
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	changed, they should explained with having was impossible for scheduled tasks and residents. Medicating should not have to verbalized it would have to sit in a wet movement to eat the not aware Resident be changed. An interview was perpendicted with NA #3. Should (B hall) too was the only NA as explained with having feel she could compliant for the residents. So able to make it three hall (B hall) for rour #3 stated she had into Resident #305 ushe changed Resident #305's enshe pulled Resident did not check if she thought having to explain the would make her and the thought should soon as possible. So incontinent care at	ge 116 inent and had requested to be ald not have to wait. She ng one NA for 28 residents it the NA's to complete all the d ADL care needed for the on Aide #4 said residents sit in incontinence to eat. She be degrading for a resident to soiled brief or bowel eir meal. She stated she was at #305 was wet and needed to erformed on 03/17/24 at 4:45 to stated her assignment on the lay had 28 residents and she signed to the hall. She ng 28 residents she did not plete all tasks and ADL care the explained she was only e-fourths of the way down her not been able to provide care that 2:00 PM. She said when the side of the explained she was tated Resident #305's sheets wet, and she had to change tire bed. She explained, when the two sheets wet. NA #3 said she at while sitting in incontinence do the resident feel terrible. The Director of Nursing (DON) B/21/24 at 4:15 PM. The DON provide incontinence care as the stated staff provided a frequency as needed per inted some residents urinate.	F	577		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345191	B. WING		C 03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	03/2//2024	
(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 APPROFIDERICIENCY)	D BE COMPLETION	
F 677	heavier and needed frequently. She staff try to make rot every 2-3 hours. Shif staff could get to it what staffing was lift turn off a call light if incontinent care. She attended to and explained the facilit weekend than during response and provibecause the administance care on. She said if no onstaff can go in the mincontinence care, of yourself does not on 3/21/24 at 4:40 performed with the Administrator stated provide incontinence care, she call light and not administrator stated bowel incontinent ebeing on the floor from incontinent care to be manner. She explain min. She said she was non-oriented reside shift for incontinent expand on what free Administrator stated and stated she coul Administrator stated and stated sh	d incontinent care more ed for non-oriented residents, ands for incontinence care the explained she was not sure that that frequency because of the She said staff should not the resident has called for the stated the call bell should should not be passed. She ty had more challenges on the tig the week with call bell ding incontinent care timely strative staff were not there. could provide bowel the said, "not being in control to make you feel good." PM an interview was Administrator. The tid she expected the staff to the care when they are that staff should not turn off to come back. The tid she would not consider a pisode emergent as someone to ma fall but would expect the to be provided in a timely the staff that the care needs. When asked to	F 67			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X2) PROVIDER/SUPPLIER/CLIA (X2) IDENTIFICATION NUMBER: A. B		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345191	B. WING		C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	33/21/2321
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 677	Continued From pag		F 67	77	
F 690 SS=D	not something that s	hey would not like it and was hould not have happened. tinence, Catheter, UTI I-(3)	F 69	90	4/24/24
	resident who is conti admission receives s maintain continence	cility must ensure that nent of bladder and bowel on services and assistance to unless his or her clinical nes such that continence is			
	ensure that- (i) A resident who en indwelling catheter is resident's clinical corcatheterization was r (ii) A resident who er indwelling catheter o is assessed for removed as possible unless that can and (iii) A resident who is receives appropriate	on the resident's ssment, the facility must ters the facility without an anot catheterized unless the addition demonstrates that necessary; afters the facility with an ar subsequently receives one aval of the catheter as soon are resident's clinical condition at the terization is necessary; incontinent of bladder treatment and services to infections and to restore			
	ensure that a resider receives appropriate				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING				27/ 2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112024	
					42 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH CEN	ITER BY HARBORVIEW			IOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Continued From page	: 119	F 6	90				
F 690	possible. This REQUIREMENT by: Based on observation Director, resident, and failed to ensure a resicollection bag was drawiewed for catheter Resident #52). The findings included 1. Resident #4 was a 06/22/23 with a diagon Dysfunction of the Blanormal bladder function damage). Review of Resident #01/04/24 and 3/20/24 a suprapubic catheter the bladder to drain untheir own). Catheter cand night shift, cathet anchor and monitor for Review of care plant of Resident #4 had an are elimination with indiversion Neuromuscular Dy Interventions included	is not met as evidenced ns, record review, Medical d staff interviews, the facility dent's urinary catheter ained for 2 of 2 residents care (Resident #4 and : ddmitted to the facility on osis of Neuromuscular adder (a condition where on is disrupted due to nerve 4's physician orders dated revealed she had orders for (device that's inserted into rine if one can't urinate on eare every shift, every day er to be secured with an or placement.	F	590	1. Immediate action(s) taken for the resident(s) found to have been affected include: "Resdent #4s catheter bag was checked 4/16/24 by the Unit Manager and ensured to be emptied. Resident #52s catheter bag was checked 4/16/24 by the Unit Manager and ensured to be emptied. 2. Identification of other residents has the potential to be affected was accomplished by: "All residents with catheters have the potential to be affected by this deficient practice. 3. Actions taken/systems put into platto reduce the risk of future occurrence include: "The Director of Nursing, Assistant DON, Unit Manager, VP of Clinical and Regional Nurse, beginning 4/18/2024, inservice RNs, Medication Aides, CNA and LPNs on the facilities Catheter Capolicy and ensuring that Urinary Cathe bags are emptied timely and as neede. "All new RNs, Medication Aides, CNAs, and LPNs will be in serviced on these items and policies during the orientation process by the DON or ADO	and ted red ving he t toce d/or will s re ter d.		
	drainage and position bag as ordered, anch tugging on the cathet delivery of care; moni urinary tract infection,	ing, change tubing/catheter or catheter, avoid excessive			" Any RNs, Medication Aides, CNAs and LPNs who have not went through training prior to the compliance date wi have to do so prior to working again. " Any Agency Staff will be educated prior to working	s, the ill		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C 03/27/2024	
		345191	B. WING				
	ROVIDER OR SUPPLIER	CENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	CODE	00/2//2024	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	DATE	
F 690	assessment dated was cognitively interequired assistance (ADL), and always On 03/17/24 at 3:5 observed in her rooreported she had a "bladder was paral followed by urology didn't have an ancebeing pulled. How did not feel like it was bag was full. Resistaff did not empty last two weeks her burst open. Reside happened to her two On 03/19/24 at 10:1 Aide (NA) #4 reveat facility for over a velast Wednesday (0 (03/14/24) that Refull it was about to in the tubing and let the bag onto the flunable to open and stated she immediated	terly Minimum Data Set (MDS) 02/02/24 revealed Resident #4 act, had an indwelling catheter, e with activities of daily living incontinent of urine. 2 PM, Resident #4 was om resting in bed. Resident #4 a catheter, because her yzed" and that she was being y. The resident stated she hor to keep the catheter from ever, she stated the catheter vas pulling until the catheter dent #4 continued to verbalize her catheter bag, and in the reatheter bag was so full it ent #4 voiced this had	F	4. How the corrective ac monitored to ensure the precur: "The Director of Nursir ADON, Unit Manager and Nurse, beginning 4/18/202 all residents with urinary oper week for 12 weeks to catheter bags have been etcatheter bags ha	ractice will not a mg (DON), for Regional 24, will assess at the ters 5 day ensure all emptied timely found during dimmediately ective action opriate. If the properties of the sponsible for the sponsible sponsible for the sponsible sponsi	ss ys y.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	1 ,) DATE SURVEY COMPLETED	
		345191	B. WING			C 03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.0.0		STREET ADDRESS, CITY, STATI	E, ZIP CODE	03/21/2024	
SURRY CO	SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW			542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 690	On 03/20/24 at 7:05 Anight shift Nurse #3 we stated the nurses were resident's catheter bather shift (7pm to 7am bags upon arrival, an in the morning. Nurse was not able to make and empty Resident stated by the time shift (7am and she gave report to 10 On 03/20/24 at 8:45 Andministrator was constated all new hires retraining during orients on the procedure. She catheter care was on nurses, and that the I was responsible for the Administrator continuor the nurses should catheter and drainage. On 03/20/24 at 2:45 If was conducted. She be emptied by a nurs to state she remember (unable to recall exact catheter bag was lead being so full; she was bag and notified the to Resident #4's catheter changed.	AM, an interview with the vas conducted. Nurse #3 re responsible for emptying ag, and when she worked by she emptied the catheter do then again before she left at #3 voiced that at times she arounds over to the B hall at times she arounds over to the B hall at times at rounds over to the B hall; and to 7pm) staff had arrived to them. AM, an interview with the anducted. The Administrator action and were checked off also stated urinary by done by med aides and Director of Nursing (DON) and training. The ed to voice that med aides be checking Resident #4's ab bag. PM, an interview with MA #2 verbalized catheters must be or MA. MA #2 continued ared one time recently at date) Resident #4's able to empty the catheter reatment nurse that	F	690			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING			l	C 27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
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F 690	Continued From page	e 122	F	690				
	verbalized that if Res was not properly asse increased the chance lead to potential harm was aware of Reside however, had no com	of an infection and could n for the resident. The MD nt #4's catheter bag incident						
	DON was conducted. new hires (nurses and urinary catheter care and annually. She stanurses were to perfor because they could a	The DON verbalized all d med aides) received training during orientation ated only med aides and m urinary catheter care, ssess the residents for any signs/symptoms of an monitor and drain the						
	08/12/22 with a diagn Neuromuscular Dysfu condition where norm	unction of the Bladder (a nal bladder function is e damage) requiring chronic						
	Resident #52 has an elimination with inducto Neuromuscular Dy Interventions included and as needed, check drainage and position bag as ordered, keep below the level of the privacy bag in place for report symptoms of united the second	elling urinary catheter related sfunction of the Bladder. d: catheter care every shift k catheter tubing for proper ling, change tubing/catheter drainage bag of catheter bladder and off floor, for dignity. Monitor and rinary tract infection, or, or consistency of urine,						

; 27/2024
.112024
(X5) COMPLETION DATE
c

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED	
		345191	B. WING			03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/21/2024	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 690	drainage bag was of milliliters (ml) of cloud milliliters (ml) of cloud on 03/19/24 at 12:4 was conducted. NA with Resident #52 a She reported when a morning (7am to 7pm catheter bag was cobeen emptied/draine (7pm to 7am). NA #reoccurring issue are bags were not being night staff, which overported she received training during her Nand voiced that's the training she received couple of months againstructed by the DC Resident #52's urina nurses or med aides. On 03/20/24 at 6:30 was conducted. She work this morning (Constructed of the constructed of the constru	PM Resident #52's catheter observed to have 1000 ady yellow urine in it. O PM an interview with NA #4 #4 stated she was familiar and had provided care for him. She came into work this m) Resident #52's urinary ampletely full and had not ad by the staff on night shift 4 voiced this was a ad that residents' catheter amonitored or emptied by the perflowed into day shift. NA #4 and urinary catheter care that training a few years ago are only true catheter care and on urse aides were on on to do anything with any catheter, and only the	F 69	,			
	complaining he felt I back up into him" ar eventfully emptied 2 from his drainage bamention again that t supposed to be empting bags. On 03/20/24 at 7:30	ike the urine was "backing id they (staff name not given) 000 milliliters (ml) of urine in ing. NA #4 continued to in it is not in it i					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345191	B. WING		C 03/27/2024
	PROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 00/21/2024
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 690	with Resident #52 a bag being full last resident's drainage arrived at work this continued to state operform catheter catheter drainage arrived at work this continued to state operform catheter drainage arrived at 8:00 Resident #52 was oreported he started "stomach/bladder" bag was full and leashift (7pm to 7am) room at all to check Resident #52 furthes staff several times a catheter bag. On 03/20/24 at 8:44 Administrator state catheter training duchecked off on the urinary catheter catheter training duchecked off on the urinary catheter catheter training duchecked off on the urinary catheter and nurses and the was responsible for Administrator continuent or the nurses should catheter and drainal On 03/21/24 at 11:4 Medical Director (Myerbalized that if Resident is stated to the stated of	and heard about his catheter hight (3/19/24). She stated the bag was emptied when she morning (7am to 7pm). She only a nurse or med aide could are and should be monitoring ge bag at least every 1-2 O AM an interview with conducted. The resident feeling pressure around his area and thought his catheter aking. He stated during night staff had not come into his cor empty his catheter bag. Er stated he had to call out to for someone to empty his AM, an interview with the diall new hires received urinary uring orientation and were procedure. She also stated re was only done by med aides a Director of Nursing (DON) or the training. The nued to voice that med aides do be checking Resident #52's age bag. AO AM, an interview with the MD esident #52's urinary catheter	F 690		
	staff several times a catheter bag. On 03/20/24 at 8:4: Administrator states catheter training du checked off on the urinary catheter car and nurses and the was responsible for Administrator continor the nurses should catheter and drainary Con 03/21/24 at 11:4 Medical Director (More than 11 of the control of the control of the nurses should catheter and drainary Con 03/21/24 at 11:4 Medical Director (More than 12 of the control of the c	for someone to empty his 5 AM, an interview with the d all new hires received urinary uring orientation and were procedure. She also stated re was only done by med aides e Director of Nursing (DON) rethe training. The nued to voice that med aides d be checking Resident #52's age bag. 40 AM, an interview with the ID) was conducted. The MD			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	SURVEY	
		345191	B. WING				C 27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030		
(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 692 SS=D	DON was conducted. new hires (nurses and urinary catheter care and annually. She stanurses were to perfor because they could a changes, monitor for infection, as well as no catheter drainage bag Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted or (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessmensure that a resident status, sidesirable body weigh balance, unless the redemonstrates that this preferences indicate of \$483.25(g)(2) Is offer maintain proper hydratic status, significant for the sides and status, sidesirable body weigh balance, unless the redemonstrates that this preferences indicate of \$483.25(g)(2) Is offer maintain proper hydratic status, significant for the sides and status, significant for the sides of	PM, an interview with the The DON verbalized all d med aides) received training during orientation ated only med aides and murinary catheter care, assess the residents for any signs/symptoms of an anonitor and drain the g as needed. Attus Maintenance (-(3)) mutrition and hydration. It is an additional and an aresident's assment, the facility must acceptable parameters such as usual body weight or at range and electrolyte esident's clinical condition is is not possible or resident otherwise; and a therapeutic diet when problem and the health care		690	 Immediate action(s) taken for the 		4/24/24

PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, , ,	OATE SURVEY COMPLETED	
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		345191	B. WING _			03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
CUDDY C	OMMINITY LIEALTH	CENTER BY HARBORVIEW		542 ALLRED MILL ROAD			
SURKTO	OMMUNIT HEALIN	CENTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
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F 692	Continued From p	age 127	F6	92			
	Director interviews a physician order the #255). The deficie	the facility failed to implement for intravenous fluids (Resident nt practice was for 1 of 3 for review of hydration.		resident(s) found to have b include: " The facility failed to im physician s order for intrave for resident #255. Resident longer resides in the facility	iplement a venous fluids t #255 no		
	02/17/2024 with dimalnutrition.	s admitted to the facility on agnoses that included		Identification of other rethe potential to be affected accomplished by: All residents who are completed.	was		
	Resident #255 wa saline intravenous milliliters per hour	dated 02/29/24 revealed s to receive 0.45% normal infusion at a rate of 85 (ml/hr) x 2 liters of fluid every as a supplement for a duration		intravenous fluids have the affected by this deficient pr 3. Actions taken/systems to reduce the risk of future include: " The Director of Nursing DON, Unit Manager, VP of	actice. s put into place occurrence g, Assistant		
	February 2024 rev normal saline intra liters for a duration revealed Medicatic Resident #255 rec on the 7:00 AM to 7:00 AM shift. Nur Resident #255 did 03/02/24 for the 7:03/03/24 for	inistration Record dated realed an order for 0.45% ovenous infusion at 85ml/hr x 2 of 3 days. The documentation on Aide #5 initialed the MAR as reived the infusion on 03/01/24 3:00 PM shift and 11:00 PM to se #6 initialed the MAR as not receive the infusion on 00-3:00 PM shift and on 00 to 3:00 PM shift. Lucted on 03/27/24 at 11:27 AM #1 revealed she had entered or dated 02/29/24 for uids for Resident #255. The she would have normally self, however it was a busy day to it. She stated the		Regional Nurse, beginning inservice RNs and LPNs or Intravenous Therapy policy that all residents with order receive their IV therapy tim ordered per the physician. will also cover ensuring that documentation is complete LPN regarding IV therapy. "All new RNs and LPNs serviced on these items and during the orientation processor ADON. "Any Staff who have not the training prior to the comwill have to do so prior to will have to working.	4/18/2024, will in the facilities of and ensuring rs for IV therapy dely and as The inservice at accurate and by the RN or as will be in and policies dess by the DON of went through inpliance date working again.		
	supplemental fluid	s were ordered by the the resident had a decrease in		How the corrective act monitored to ensure the practice.			

Facility ID: 953479

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING_			C 03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 037.	2112024
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SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW			OUNT AIRY, NC 27030		
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F 692	Continued From page	e 128	F 6	692			
	stated she was in cha 02/29/24 and did not know Resident #255 interview revealed sh #6 on 03/01/24 who a ever had an IV and w She stated she did no question and that the further on Monday. Ti identified on Monday #255's IV fluids had no ordered and the facili Medical Services (EM for the resident.	xperiencing a decline. She arge of the resident's hall on let the oncoming nurse needed an IV started. The e received a call from Nurse asked if Resident #255 had ere his fluids completed. It is that yould have to investigate the interview revealed she 03/04/24 that Resident lever been initiated as ty contacted Emergency IS) to come and start and IV			recur: " The Director of Nursing (DON), ADON and/or Regional Nurse, beginn 4/18/2024, will review all intravenous fl orders 5 days per week for 12 weeks to ensure all orders for intravenous fluids implemented as ordered and documentation is completed accurately. " Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the DON as appropriate. " The Audit findings will be reported the DON in a Monthly QAPI meeting for minimum of 3 months	uid o are /. g y by or a	
	#5 on 03/27/24 at 11: PM with no return pho An interview conductor with Nurse #6 reveale Resident #255 during 03/02/24. He stated h for the resident and w he had an IV in place not have an IV or IV f The interview reveale his shift because he of	mpted with Medication Aide 50 AM, 2:13 PM and 3:34 one call received. ed on 03/27/24 at 6:45 PM ed he was responsible for a first shift on 03/01/24 and he saw the order for IV fluids went into the room to see if be the stated the resident did luids running in the room. ed he did not initiate an IV on called Unit Manager #1, and ald investigate it further on			5. The administrator is responsible for execution of this plan with a compliance date of 4/24/2024.		
	An interview conducted with Nurse #11 reveat Director of Nursing (Director of States) asked to initiate an IV stated once she entershe attempted to initial	•					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING					
		345191	B. WING _			C 03/27/2024		
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 692	Continued From page	e 129	F 6	92				
	the facility and start the #11 stated Resident # fluids in the room who on 03/04/24.	Services (EMS) to come to the resident's IV fluids. Nurse \$255 did not have an IV or IV then she first entered the room						
	with the Director of N family member had constated Resident #255 fluids and did not. She asked Nurse #11 to some she reviewed Reside Medication Aide #5 whad IV fluids and she The DON stated Nurse	ed on 03/27/24 at 11:56 AM ursing (DON) revealed a ame to her on 03/04/24 and was supposed to have IV e stated she immediately tart the IV. She stated once at #255's MAR she spoke to ho stated the resident never had documented in error. See #6 should have initiated and the resident did not have						
	with the Medical Direction an order for IV fluids for Resident #255. He values were not abnot observed to have dry benefit from IV fluids. he expected nursing regarding medication harm or negative oute the delay in care. He Monday 03/04/24 and	ed on 03/27/24 at 2:15 PM ctor revealed he had written as a prophylactic measure e stated the resident's lab rmal, but the resident was lips and he felt like he would. The Medical Director stated staff to follow his orders or IV fluids but there was no come for Resident #255 for stated he was notified on the gave a verbal order to fer the facility realized the						
F 697 SS=K	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Man		F 6	97		4/24/24		
	The facility must ensu	re that pain management is						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				SURVEY LETED
		345191	B. WING			C 03/27/2024	
NAME OF P	ROVIDER OR SUPPLIER	0.40101		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	03/.	27/2024
OUDDY O	> • • • • • • • • • • • • • • • • • • •	NITED DV HADDODVIEW	542 ALLRED MILL ROAD		2 ALLRED MILL ROAD		
SURRY CO	DMMUNITY HEALTH CEI	NTER BY HARBORVIEW	MOUNT AIRY, NC 27030		OUNT AIRY, NC 27030		
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F 697	Continued From page	e 130	F6	697			
F 697	provided to residents consistent with profest the comprehensive properties and the residents' go. This REQUIREMENT by: Based on observation resident, resident rep Medical Director (MD and staff interviews, to resident's pain (Resident's pain (Resident's pain (Resident's pain (Resident's pain (Resident's pain (Resident)). Resident # 7:00 PM). Resident # 7:00 PM). Resident # 7:00 PM). Resident # 7:00 PM). Resident # 8:00 PM; and the facion of November 2023 straight (MA) # 3 the facion Methadone (analgesi would tell her that she medication and never Resident # 21 informed her pain medications On 1/05/24 Resident reported increased particular reported reported increased particular reported increased particular reported increased particular reported increased particular reported	who require such services, ssional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced n, record review and resentative, Pharmacy,), Physician Assistant (PA), the facility failed to address a dent #21) after repeated the had not received her pain the night shift (7:00 AM to #21 reported starting the end the was told by Medication lity had run out of her copioid agonist), or MA #3 the would bring her pain return during the night shift. The dethe PA on 12/12/23 that the were not being given to her. #21 was seen by the PA and the pain primarily at night. It was seen by the PA and the primarily at night. It was seen by the PA and the pain primarily at night. It was seen by the PA and the pain primarily at night. It was seen by the PA and the pain primarily at night, had the pain the night, had the, and reported her anxiety ause she was 'terrified all all the pain the night, had the pain the primarily at night, had the pain the primarily at night.	F	697	Immediate action(s) taken for the resident(s) found to have been affected include: Resident #21's Medical Doctor (MD) was called on 3/21/24 and stated that it was unsafe to give her anymore pain medications at this time. The MD agree and the resident agreed to be evaluated a pain clinic. The resident visited the Bethany Pain Clinic on 4/9/24. The provider at the clinic would not see or adjust the resident's medication because of how high the resident was interviewed the DON on 4/22/24 again about seeing another pain clinic or doctor about her pain and she says that she does not was to go anywhere else at this time. Identification of other residents having a potential to be affected was accomplish by: The facility has determined that all residents have the potential to be affected. Actions taken/systems put into place to reduce the risk of future occurrence	ed d at by g ant the	
	Resident #21 reporte night to PA. Immedia	d increased pain primarily at te jeopardy was removed on a facility implemented a			include: The DON, ADON and/or Regional Nurs	se	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345191	345191 B. WING		C 03/27/2024	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.0.		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	3/2//2024
TVAINE OF T	TO VIDER OR GOLT EIER					
SURRY CO	MMUNITY HEALTH CE	NTER BY HARBORVIEW		542 ALLRED MILL ROAD		
				MOUNT AIRY, NC 27030		
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F 697	Continued From page	e 131	F 69	97		
F 697	credible allegation of removal. The facility compliance at a lower (no actual harm with that is not immediate education is complete put into place are effect that is not immediate education is complete put into place are effect that is not immediate education is complete put into place are effect that is not immediate education is complete put into place are effect that is not immediate and included that is not immediately a series of the lower half disorder, hereditary a (nerve pain), assault discharge, neuromus bladder, major depreheadache, chronic padependence. A review of Resident revealed the following that is not immediately a series of the seri	will remain out of r scope and severity of "E" a potential for minimal harm jeopardy) to ensure ed and monitoring systems ective. I: Idmitted to the facility on oses which paralysis that of the body, anxiety and idiopathic neuropathy by unspecified firearm cular dysfunction of the ssive disorder, insomnia, ain syndrome, and opioid #21's physician orders g: 2023 through 12/18/2023 for ams to be administered two	F 69	began in person educating on a with all Nurses and Medication (MAs) on the Controlled Substa Administration and Accountabil documenting response to as not controlled pain medications on and importance of providing paredications per the physicians ensuring appropriate pain man control the residents level of paresidents pain is not controlled physician must be called for further treatment and if the medication available they must call the phyget alternate treatment that is a per physicians orders. All will be educated prior to their next shift any agency staff. The DON is for ensuring and tracking that a and MAs are educated. The DADON will be responsible for k with who has and has not beer and completing the education to rassigning the Regional Nurso Operations or VP of Clinical to training as needed. The Regional Paredications of the Regional Regional Regional Regional The Reg	s Aides ance lity policy, eeded the MAR ain corders, agement to ain, if the the the rther is not ysician to available be fit including responsible all Nurses ON and/or eeping up inserviced hemselves ee, Regional assist with anal Nurse,	
		/2023 through 12/18/2023 lligrams to be administered for pain.		Regional Operations or VP of 0 were they notified of the respont 3/22/24. All Nurses and Medications Air	nsibility on	
	An order dated 11/2/24 through 1/5/2024 Lyrica 100 mg (6:00 am, 2:00 pm, and 9:00 pm).			will be reeducated starting 4/18 DON, ADON, Unit Manager, Vland/or Regional Nurse on the 0	3/24 by P of Clinical	
	11/20/2023 revealed cognitively intact and behaviors. It was do	Data Set (MDS) dated Resident #21 was had not exhibited any cumented that Resident #21 cations (Methadone) daily		Substance Administration and Accountability policy, documen response to as needed controll medications on the MAR and ir of providing pain medications p	ed pain mportance	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			TE SURVEY MPLETED	
		345191	B. WING _			0.3	C 3/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030	, ,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Review of a grievan completed by the Bubehalf of Resident # documentation on the Methadone was on been administered projector of Nursing (on 12/1/2023. No further decision was a review Resident # documentation reversall numbers from a "2023. 16 of the 31 of Resident #21's pain or greater on a scale An interview was con 12:18 pm with Resident #21's pain or greater on a scale (MA) #3, that the was told by a night shade (MA) #3, that the Methadone, the phase of her pain medication would tell her that she medication and never frequently beginning Resident #21 report time without getting 6:00 AM dose) and	k back period for pain. ce dated 11/30/2023 was usiness Office Manager on 21. The handwritten he grievance form noted the medication cart and had ber documentation. The 1DON) signed the grievance for investigation, summary a conclusions, or the date the resisted were documented. 21's pain scale aled her pain was scored at 10" to "10" during December days in December 2023, was documented as a seven the of 1 to 10. Inducted on 3/18/2024 at 12. Resident #21. Resident #21. Resident #21. Resident #21. Resident #21 are not of November 2023 she shift staff member, Medication the facility had run out of her remacy had not sent enough on at one time, or MA #3 are would bring her pain the return. This occurred more in December of 2023 and the Methadone (9:00 PM and experienced severe anxiety,	F	697	physicians orders, ensuring appropriation management to control the reside level of pain, if the residents pain is not controlled the physician must be called further treatment and if the medication not available they must call the physicito get alternate treatment that is available per physicians orders. All new Nurses and MAs will be in serviced on these items and policies during the orientation process by the Dor ADON. Any staff who has not went through the training prior to the compliance date with have to do so prior to working again. Any Agency staff will be educated prior working. How the corrective action(s) will be monitored to ensure the practice will not recur: Beginning 4/18/24 the ADON, Regional Nurse and/or DON will conduct a rando audit of 10 residents weekly for four consecutive weeks then ten resident's biweekly for 2 months. The audit will assess if the resident has complained pain and if so if the resident was provice prescribed pain medicine in a timely	nts t t for is an ble ON e II	
	to 10, and went thro which included anxion headache. She rep- filed about the facilit	reater than ten on a scale of 1 ugh 'withdrawal symptoms' ety, pain, nausea, and a orted a grievance had been y running out of her nd of November 2023 and			manner. Any deficient practice found during the audits will be corrected immediately an education and/or corrective action done by the DON as appropriate.	d	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				27/ 2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21,202-
				54	42 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(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 697	Continued From page	e 133	F 6	697			
	that no one had addre				The Audit findings will be reported by the DON in a Monthly QAPI meeting for a minimum of 3 months.	he	
	12:43 pm with Resider reported she had been (MA) #3 that the facility running out of her Meafter not receiving her medications at night, approximately three control been receiving her and was experiencing #21 reported her pair scale of 1 to 10, she had her anxiety was during the times she of her Methadone she anxiety, pain, nervous and as though she was Resident #21 could in stated she reported the stated she reported the stated she reported to the stated she reported the stated she reported to the stated she reported she reported to the stated she reported she reported she reporte	ducted on 3/19/2024 at ent #21. Resident #21 en told by Medication Aide ity had been continually ethadone around Christmas represcribed pain. From around Christmas to per four weeks ago she had er pain medications at night generated pain. Resident in was greater than a ten on a would cry during the night, out the roof.' She reported was told the facility was out er would have increased sness, nausea, a headache, as 'having withdrawal.' ot recall specific names but the increase in pain to nurses shift as well as the Physician			The Administrator is responsible for the execution of this plan with a compliant date of 4/24/2024		
	getting her Methadon or before Christmas a weeks ago. She repo December 2023 MA a almost every night an scheduled Methadon She reported, in Dece experienced terrible/a						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345191	B. WING _				27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CEI	NTER BY HARBORVIEW	•	542	REET ADDRESS, CITY, STATE, ZIP CODE 2 ALLRED MILL ROAD DUNT AIRY, NC 27030	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	e 134	F	697			
		d she would cry during the very time she experienced					
	time for 28 of 31 days	imecard revealed reported s in December of 2023 when to Resident #21's hall.					
	dated 12/12/2023 for Resident #21 was pla Resident #21 had exp pain medications wer stated "I should have [Methadone]. It's just	cian Assistant (PA) note Resident #21 revealed aced on rounds for anxiety. pressed frustration that her re not being given to her and been told it was the last one a death sentence." The PA cations had been ordered.					
	12:21 pm with the Ph PA reported she saw visits and for any spo arise. She reported a had discussed taperii because she wanted unable to recall Resident getting her pain mot suspected any iss reported if Resident pain, she would chec write another script to had the medications not able to remember wrote in her note on remember Resident pain Resident #21 had med Methadone was a 'de	to get off it. The PA was dent #21 reporting she was needication at night and had sues with diversion. She #21 had reported increased k with the Unit Manager, and o ensure that the resident she needed. The PA was redetails about what she 12/12/2023 and did not #21 saying that she was neat night. She reported entioned being started on eath sentence' because she stop taking it and would be					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW	1	STREET ADDRESS, CITY, STATE, ZI 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	P CODE	,
(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 ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI O THE APPROPRIA	DATE
F 697	Resident #21 reveal for chronic pain. The told that insurance he authorization specificate had been on for #21 had told her "I were never started me on An interview was come with the Pharma Representative. She authorization for Me	note dated 12/18/2023 for ed she was placed on rounds e PA noted the resident was lad requested a prior cally on Methadone which quite some time. Resident vish hospice would have it [Methadone]." Inducted on 3/19/2024 at 9:18 cy Quality Assurance e reported review of the prior thadone was approved for the	Fé	697		
	amount ordered. The submit a different primedication amount of request. The medicand dispensed to the authorization was try not aware of any dispensed the resident #21's Method.	nadone.				
	1/4/2024 revealed a 5/29/2023 that state a change in comfort syndrome. Residen interventions related having pain medicat Medical Doctor (MD observe for signs an pain medications (contange in level of comental status).	•				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345191	B. WING _			C 03/27/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	03/2//2024
				542 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE
F 697	Continued From page	e 136	F 6	697		
		ident #21 reported increased t and while working with				
	(nerve pain medication administered three times	s written on 1/5/24 for Lyrica on) 150 mg to be mes per day (6:00 am, 2:00 neuropathy (nerve pain).				
	2/13/2024 revealed F intact and had not ex was documented tha	Data Set (MDS) dated Resident #21 was cognitively hibited any behaviors. It t Resident #21 received Methadone) daily during the od for pain.				
	pm with Resident #22 Resident Representa #21 was continuously facility had run out of (Methadone) and Regrievance on 11/30/2 the middle of Februa facility had told Resident sent it. She recamultiple times during 2023 until February 2 frightened because signing to get her med speaking in person with Nursing (ADON) abor Resident #21's medic ADON told her she with not know that Reside of her Methadone, arthe issue or follow up	sident #21 had filed a 023. This continued through ry 2024. She reported the lent #21 the pharmacy had led her daughter calling her the night from December				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C 3/27/2024	
	PROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		5/21/2024	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	pm with MA #3. MA longer employed at a terminated approxim reported Resident # Methadone a lot and days at a time and w She reported the iss being discharged froi insurance requiring a medication. MA #3 ralways in a lot of pair reports of increased A telephone interviet 3/21/2024 at 8:04 an NA #8 reported Resincreased pain at nigdid not get her Methassigned to her. Sh had complained they medications either approached MA #3 would get up seen her go give the NA #8 indicated she concerns to adminis an explanation for w resident's concerns. An interview was coam with Nurse #2. Nowrked on night shiff Resident #21. She complain of increases	nducted on 3/19/2024 at 1:10 #3 reported she was no the facility and had been hately one month ago. MA #3 21 would run out of would report increased pain. He was due to Resident #21 He Hospice services and her hat a prior authorization for the he eported Resident #21 was hand did not relay any hain to the MD or PA. What was conducted on hat with Nurse Aide (NA) #8. He had had reported that she had had reported that she had not gotten their She stated that she had had round on the had not had report the residents, had not gotten their had not report the resident's had not report the resident's had not report the resident's had not report the had not have hy she did not report the	F 6	97			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			03/2	27/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	1 00/2	172024
CLIDDY C	OMMILINITY HEALTH CE	NTER BY HARBORVIEW		542 ALLRED MILL ROAD			
SURKTO	JININIONITT HEALTH CE	VIER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 697	Continued From page	e 138	F 6	97			
	indicated Resident #2 Nurse #2 indicated sl resident's concerns to not have an explanat report the resident's of An interview was con	o administrative staff and did ion for why she did not concerns. ducted on 3/21/2024 at 8:10					
	hall nurse and had w facility until October 2 #3 would routinely wo 300-hall. She reporte finding MA #3 at nigh go outside and would verbalized residents MA #3 had not given medications. Nurse at the MARs MA #3 h	#4 stated when she looked					
	she would approach not receiving their me her she had pulled ar medications but had #4 reported she had back and administer pulled, and residents they never received to the issue to the ADO last occasion being 1 just don't have any he know what to do.' Nu concerns to the Admi will take care of it.' Shad verbalized she do they were ordered ar	MA #3 about the residents edications, MA #3 would tell and documented their not given them yet. Nurse not witnessed MA #3 go the medications that she would continue to tell her hem. Nurse #4 had reported N on several occasions, the 0/22/2023, and was told 'we elp on third shift, I just don't urse #4 also reported her nistrator who told her 'We he reported Resident #21 dn't get her medications as					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP (542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	CODE	00/21/2021
(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 ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	DATE
F 697	frequently come to he Director of Nursing (E ADON stated she did her residents were nowhen assigned to Mapulling medications a administered without She reported there had administered without She reported there had a 16-hour shifts) most only able to recall Rereporting Resident #2 could not recall when stated the pharmacy out of Methadone. So reported to her that the Resident #21's Methanot received her Methadone was the pharmacy out of Methadone. So reported that she had because the pharmacy out of Methadone. So reported that she had because the pharmacy out of Methadone was company with the DON. The #21's had called her around the time a grid (11/30/2023) and told had her Methadone was in the were correct, and Methadone was in the med cart and continued in the poon confirmed a further investigation,	d December staff would er with concerns due to the DON) being on leave. The not recall Nurse #4 telling of getting their medications a #3 or that MA #3 was and charting them as giving them to the residents. and not been any issues with yed working and would work N reported MA #3 would and work until 7:00 am days of the week. She was sident #21's Representative 21 was out of Methadone but this occurred. The ADON had never let the facility run he stated the RR had and ne facility had run out of adone and Resident #21 had nadone. The ADON In not investigated the issue by had never let the facility e. She verbalized that she with the RR. ducted on 3/19/2024 at 3:16 and DON reported Resident Resident Resident Resident Resident Resident #21's e medication cart, the counts	F6	697		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345191	B. WING			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	DDE	00/21/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 697	Continued From page	ge 140	F	697		
	10:50 am with the A Administrator report Resident #21 had re her Methadone at n and Resident #21 h running out of her M was not aware of ar #21's Methadone ar grievance filed by R Administrator deniethe RR's visit and w reporting any conce Administrator report 2/14/24 because sh than any other staff when they cut her h had attempted to ge she could have their	ed she was not aware eported she was not receiving ight, having increased pain ad been told the facility was lethadone. She reported she by issues obtaining Resident and was not aware of the esident #21. The dight the ADON telling her about as not able to recall Nurse #4 arns about MA #3 to her. The led MA #3 was terminated on the ewas working more hours member and became upset ours. She reported MA #3 at other staff to call in so that in hours.				
	3/21/2024 at 10:50 taken care of Residbeen a patient of his He reported that me pretty reliable histor get anxious, upset, The MD reported the been a challenge for recall Resident #21 received her Methar reported withdrawal after 3 to 5 days and vomiting, increased issues. He reported Methadone for a lor dangerous to take his	anducted with the MD on am. The MD reported he had ent #21 and that she had in the primary care setting. Edically Resident #21 was a ian. He reported she could and fixated on things at times. The primary care setting at pain management had reporting she had not done at night. The MD from Methadone could occur de would cause nausea, pain, and possibly cardiacts are reporting she had not done at night. The MD from Methadone could occur de would cause nausea, pain, and possibly cardiacts are reported to the set of the primary to each of the set of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED			
		345191	B. WING _		1	C / 27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 03	2112024
(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 AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 697	Continued From pa	ge 141	F 6	97		
	by a Cardiologist.					
	The Administrator w Jeopardy on 3/21/2	vas notified of Immediate 024 at 6:25 pm.				
		d the following credible liate Jeopardy Removal:				
		cipients who have suffered, or a serious adverse outcome compliance:				
	repeated reports the pain medications du told by staff the med Residents #21 infor amount of pain that	o address Resident #21's at she had not received her uring the night shift and being dications were not available. med staff of the increased she was having from not uled medications as ordered.				
	3/21/24 by the Assis (ADON). The residwill always be an 8-her. She displayed during the assessm building model house denied not receiving time. Her pain medithe ADON on the montrolled medication. The resident's Mediand stated that it was pain medications at and the resident agricultic. An appointm as possible. The Al 3/22/24 and had to	in level was evaluated on stant Director of Nursing ent stated that her pain level 10 and it's a daily battle for no signs or symptoms of pain ent. She was smiling and ses during the interview. She g her pain medication at this lications were inventoried by edication cart and the ons were at appropriate levels. Ical Doctor (MD) was called as unsafe to give her anymore this time. The MD agreed reed to be evaluated at a pain ent will be scheduled as soon DON called the pain clinic on leave a message with no call closed on the weekend and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 3/27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		3/21/2024	
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 697	Continued From pag	e 142	F 6	97			
	will be called again Nappointment.	londay to follow up for an					
	review the Resident Administration Record Wednesday, Friday) medications were given Resident #21 if her padministered as order - On 3/21/24 the DOI (MDS) Coordinator, I assessment on all repain needs/change in residents were interview.	rd 3 days per week (Monday, to ensure that pain ven as ordered and ask vain medications have been ered. N, ADON, Minimum Data Set MDS nurse completed a pain sidents to identify any unmet in pain. Cognitively intact					
	stated that her pain we this time with her cur additional resident id Medical Doctor notific with new orders give titrated to Three time						
	process or system fa	the entity will take to alter the illure to prevent a serious m occurring or recurring, and be complete:					
	in person educating and Medications Aide Substance Administr policy, documenting controlled pain medications	nd/or Regional Nurse began on 3/22/24 with all Nurses es (MAs) on the Controlled ation and Accountability response to as needed cations on the MAR and ing pain medications per the					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1			DATE SURVEY COMPLETED
	345191	B. WING _			C 03/27/2024
	ENTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		•	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION	I SHOULD BE	(X5) COMPLETION DATE
physicians orders, of management to corpain, if the residents physician must be of if the medication is the physician to get available per physician tracking and tracking are educated. The responsible for keep and has not been in education themselv Nurse, Regional Opwere notified of the and/or Agency Nurse also be inserviced of taking a resident as a resident as a resident with contribution of pain the process of residents with contribution of pain adequate levels are running out of pain Alleged date of IJ responsible to the process of the proc	ensuring appropriate pain atrol the residents level of a pain is not controlled the salled for further treatment and not available they must call alternate treatment that is sians orders. All will be eir next shift including any DON is responsible for any that all Nurses and MAs DON and/or ADON will be bing up with those who have eserviced and completing the es or assigning the Regional perations or VP of Clinical to as needed. The Regional perations or VP of Clinical responsibility on 3/22/24. New see and Medication Aides will during orientation or before signment. Sand/or Nursing Supervisor will and 3/22/24 of checking all colled medications y/Friday to ensure that the on hand to not be at risk of medications. Semoval: 3/23/24 Cility's immediate jeopardy calidated through record review on all sees assessments on all	F	697		
residents to identify	any unmet pain needs. The				
	SUMMARY S (EACH DEFICIEN REGULATORY OF REGUL	SUMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 143 physicians orders, ensuring appropriate pain management to control the residents level of pain, if the residents pain is not controlled the physician must be called for further treatment and if the medication is not available they must call the physician to get alternate treatment that is available per physicians orders. All will be educated prior to their next shift including any agency staff. The DON is responsible for ensuring and tracking that all Nurses and MAs are educated. The DON and/or ADON will be responsible for keeping up with those who have and has not been inserviced and completing the education themselves or assigning the Regional Nurse, Regional Operations or VP of Clinical to assist with training as needed. The Regional Nurse, Regional Operations or VP of Clinical were notified of the responsibility on 3/22/24. New and/or Agency Nurses and Medication Aides will also be inserviced during orientation or before taking a resident assignment. - The DON, ADON and/or Nursing Supervisor will begin the process on 3/22/24 of checking all residents with controlled medications Monday/Wednesday/Friday to ensure that adequate levels are on hand to not be at risk of running out of pain medications. Alleged date of IJ removal: 3/23/24 On 03/26/24, the facility's immediate jeopardy removal plan was validated through record review	A BUILDI ROVIDER OR SUPPLIER DMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 143 physicians orders, ensuring appropriate pain management to control the residents level of pain, if the residents pain is not controlled the physician must be called for further treatment and if the medication is not available they must call the physician to get alternate treatment that is available per physicians orders. All will be educated prior to their next shift including any agency staff. The DON is responsible for ensuring and tracking that all Nurses and MAs are educated. The DON and/or ADON will be responsible for keeping up with those who have and has not been inserviced and completing the education themselves or assigning the Regional Nurse, Regional Operations or VP of Clinical were notified of the responsibility on 3/22/24. New and/or Agency Nurses and Medication Aides will also be inserviced during orientation or before taking a resident assignment. - The DON, ADON and/or Nursing Supervisor will begin the process on 3/22/24 of checking all residents with controlled medications Monday/Wednesday/Friday to ensure that adequate levels are on hand to not be at risk of running out of pain medications. Alleged date of IJ removal: 3/23/24 On 03/26/24, the facility's immediate jeopardy removal plan was validated through record review and interviews: On 03/21/24 the DON, ADON, MDS Coordinator, MDS nurse completed pain assessments on all residents to identify any unmet pain needs. The	ROWDER OR SUPPLIER TOMMUNITY HEALTH CENTER BY HARBORVIEW SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 143 physicians orders, ensuring appropriate pain management to control the residents level of pain, if the residents pain is not controlled the physician must be called for further treatment and if the medication is not available they must call the physician to get alternate treatment that is available per physicians orders. All will be educated prior to their next shift including any agency staff. The DON is responsible for ensuring and tracking that all Nurses and MAs are educated. The DON and/or ADON will be responsible for keeping up with those who have and has not been inserviced and completing the education themselves or assigning the Regional Nurse, Regional Operations or VP of Clinical to assist with training as needed. The Regional Nurse, Regional Operations or VP of Clinical were notified of the responsibility on 3/22/24. New and/or Agency Nurses and Medication Aides will also be inserviced during orientation or before taking a resident assignment. -The DON, ADON and/or Nursing Supervisor will begin the process on 3/22/24 of checking all residents with controlled medications Monday/Wednesday/Firday to ensure that adequate levels are on hand to not be at risk of running out of pain medications. Alleged date of IJ removal: 3/23/24 On 03/26/24, the facility's immediate jeopardy removal plan was validated through record review and interviews: On 03/21/24 the DON, ADON, MDS Coordinator, MDS nurse completed pain assessments on all residents to identify any unmet pain needs. The	A BUILDING 345191 A STREETADDRESS, CITY, STATE, ZIP CODE \$42 ALLRED MILL ROAD MOUNT AIRY, NC 27030 SUMMARY STATEMENT OF DESPOSACION (EACH DESPCISION ON THE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 143 Physicians orders, ensuring appropriate pain management to control the residents level of pain, if the residents pain is not controlled the physicians orders, ensuring appropriate pain management to get alternate treatment that is available per physicians orders. All will be educated prior to their next shift including any agency staff. The DON is responsible for ensuring and tracking that all Nurses and MAS are educated. The DON and/or ADON will be responsible for keeping up with those who have and has not been inserviced and completing the education themselves or assigning the Regional Nurse, Regional Operations or VP of Clinical to assist with training as needed. The Regional Nurse, Regional Operations or VP of Clinical to assist with training as needed. The Regional Nurse, Regional Operations or vP of Clinical to assist with training as needed. The Regional Nurse, Regional Operations or VP of Clinical to assist with training as needed. The Regional Nurse, Regional Operations or VP of Clinical were notified of the responsibility on 3/22/24. New and/or Agency Nurses and Medication Aldes will also be inserviced during orientation or before taking a resident assignment. -The DON, ADON and/or Nursing Supervisor will begin the process on 3/22/24 of checking all residents with controlled medications. Alleged date of IJ removal: 3/23/24 On 03/26/24, the facility's immediate jeopardy removal plan was validated through record review and interviews: On 03/21/24 the DON, ADON, MDS Coordinator, MDS nurse completed pain assessments on all residents to identify any ummet pain needs. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X:	3) DATE SURVEY COMPLETED
	345191	B. WING _			C 03/27/2024
NAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH CE	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	· ·	33/21/23/21
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Substance Administr policy and document Administrative staff in completed the educate medication Aids. The supervisors will begin controlled medication and Friday to ensure cart that are needed out of ordered pain in administration stated nurses and medication will continue with this employees. Interview they had received transubstance on 03/22/orientation sheet. The that staff had signed The IJ removal date Sufficient Nursing Stafficient Nursing Stafficient Nursing Stafficient The facility must have the appropriate comparation of each resident safety and a practicable physical, well-being of each reresident assessment and considering the indiagnoses of the faciliaccordance with the at §483.35(a)(1) The facility Th	dication aids on Controlled ation and Accountability ing response on 03/22/24. Interviews revealed they had ation for all nursing staff and the DON, ADON, and nursing in checking all residents with the on Monday, Wednesday, that medications are in the to prevent residents running medications. Interviews with the training was completed for on aids and that the training is training with new with nursing staff revealed atining on Controlled 24 and had signed off on an one orientation sheet reveals off on the training. Of 3/23/24 was validated. The sufficient nursing staff with pretencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial sident, as determined by its and individual plans of care	F 6			4/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		!	33/21/2324
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
F 725	nursing care to all reresident care plans: (i) Except when wait this section, licensed (ii) Other nursing per limited to nurse aided §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of this REQUIREMENT by: Based on record reand staff interviews, sufficient nursing start preference for show (Resident #59 and Febaths, showers, and dependent residents Resident #59, and Freviewed for sufficient The findings included This tag was cross-testing was cross-testing was cross-testing to a sufficient residents and staff in provide baths and scare for residents reassistance with activity and staff in the sufficient residents and scare for residents reassistance with activity and staff in the sufficient residents and scare for residents reassistance with activity and staff in the sufficient residents and scare for residents reassistance with activity and staff in the sufficient residents and scare for residents reassistance with activity and sufficient residents reassistance with activity and staff in the sufficient residents reassistance with activity and staff in the sufficient residents reassistance with activity and staff in the sufficient residents reassistance with activity and sufficient residents	on a 24-hour basis to provide esidents in accordance with eved under paragraph (e) of d nurses; and rsonnel, including but not es. of when waived under a section, the facility must d nurse to serve as a charge of duty. It is not met as evidenced eview, observations, resident the facility failed to provide aff to honor a resident's ers for 2 of 4 residents are section and to provide a incontinence care to a for 3 of 8 (Resident #4, are section #4, are section #305) residents nt nursing staff. d: referenced to: servations, record review, terviews, the facility failed to howers, and incontinence quiring or dependent on staff vities of daily living (ADLs).	F7	Immediate action(s) taken for resident(s) found to have beer include: The facility failed to provide su nursing staff to honor a resider preference for showers for 2 or residents (Resident #59 and R#256) and to provide baths, shincontinence care to depender for 3 of 8 (Resident #4, Reside Resident #305) residents revies sufficient nursing staff. Reside longer resides in the facility. R 59, 4, and 305 are current resifacility and were questioned by Administrator on 4/16/24 and Infurther concerns.	fficient on t's f 4 desident sent #59, and ewed for on t # 256 no esidents # dents in the y the	
	F561 - Based on res	esidents reviewed for ADLs. sident, staff interviews and acility failed to honor e for showers. This was for 2 wed for choices.		Identification of other residents potential to be affected was acby:	-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345191	B. WING				27/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21/2024	
				54	42 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		M	OUNT AIRY, NC 27030			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 725	Continued From page	e 146	F	725				
					All residents have the potential to be			
		n interview was conducted with Nurse #3 on			affected by this deficient practice.			
		Nurse #3 revealed she						
	_	e facility in January 2023 and			Actions taken/systems put into place to)		
		0 PM to 7:00 AM). She			reduce the risk of future occurrence			
		2023 her resident assignment			include:			
		sidents to 60 residents which			The VP of Clinical inserviced the Direct	tor		
		facility no longer using a se #3 stated the Nurse Aide			of Nursing and Administrator on 4/17/2			
		e assigned 30 residents and			on ensuring that there is always adequ			
	` '	s, up to 60 residents. She			nursing staff in the building.	ato		
		re not able to complete their			marching clair in the banding.			
	tasks and she had to	•			Starting 4/18/24 the Director of Nursing	1,		
	activities of daily livin	g (ADLs) which made			Assistant DON, Regional Nurse, VP of			
	_	ng tasks difficult. Nurse #3			Clinical and/or Unit manager will provide			
	stated on 3/19/24 she	e did not have a NA assigned			education to Nurses, Medication Aides			
	to her halls from 5:00	AM to 7:00 AM and she had			and CNAs on the Activities of Daily Livi	-		
		th ADLs which prevented her			policy and the importance of ensuring t	hat		
	from completing her				Showers, Incontinent care and all ADL			
	,	Nurse #3 further stated			care is provided as needed for all			
	there were not suffici	ent staff to meet the			residents.			
	residents' needs.				Charting 4/40/04 the VD of Olivinal			
	Δn interview was con	nducted with Nurse Aide (NA)			Starting 4/18/24 the VP of Clinical, Regional Nurse, Administrator, Directo	r of		
		6 AM. NA #7 revealed she			Nursing, Assistant DON, and/or Unit	. OI		
	l	to 7:00 AM shift and was			manager will provide education to all st	aff		
		hall. NA #7 stated she had			on the Quality of Life-Dignity policy and			
	_	er assignment which made it			the importance of ensuring that Dignity			
		all her tasks. NA #7 indicated			maintained with regards to timely			
	she was not able to o	complete all the resident			incontinence care.			
	showers and baths s	cheduled on her shift due to						
	not having enough st	aff.			Aggressively recruiting to hire new staf	f.		
					We are offering sign on bonusses for			
		nducted with Nurse #10 on			CNAs and Nurses beginning 4/18/24 w	ith		
		Nurse #10 stated she worked			a tentative end date of 6/15/24.			
	7:00 AM to 7:00 PM				04	. :		
		NA scheduled to her hall for			Starting 4/19/24 we began utilizing outs			
		e revealed the NAs had resident care and they were			Agency to assist with staffing adequate	ıy.		
	LUMBOULY COMBREMENT I	COLUCIIL CALE ALIU ILIEV WELE	1				1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, , ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _		0	C 3/27/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0/2//2024	
				542 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CEN	ITER BY HARBORVIEW		MOUNT AIRY, NC 27030			
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F 725	Continued From page 147 not able to complete resident showers/baths as		F 7	725 Starting 4/23/24 the Adminis	strator and/or		
	scheduled. An interview was con (MA) #6 on 3/20/24 a schedule varied and s AM - 7:00 PM) and 2r She stated she was a residents and there w hall. She indicated 1 sufficient to meet the had to assist the NAs stated because she w care it was difficult for administering medica.	ducted with Medication Aide t 6:55 AM. MA #6 stated her she worked both 1st (7:00 nd (7:00 PM - 7:00 AM) shift. ssigned 2 halls with 55-60 ras 1 NA assigned to each NA to 30 residents was not residents' needs and she with resident care. MA #6 ras assisting with resident her to complete her task of		Director of Nursing will evaluate schedules for the following of day to evaluate staffing adeneed for additional staff. All new Nurses, Medication CNAs will be in serviced on and policies during the orier by the DON or ADON. Any Nurses, Medication Aid that have not went through the prior to the compliance date do so prior to working again. All Agency staff will be educed.	day(s) each quacy and the Aides and these items atation process es or CNAs the training will have to		
	AM. The ADON state hired 2 weeks ago an training, she continue schedule. She stated schedule1 NA to 15 rd to 30 residents. She staffing challenges the after call outs the avewas 1 NA to 30 reside 60 residents. The AD having an assignmen difficult to complete the complete resident she ADON indicated she incontinent care and the residents when staffir indicated she communimportance of answer letting them know stated and would return to a	and a new scheduler was digital while they completed digital to manage the nursing at the facility's goal was to residents and 1 Nurse or MA further stated with the rey were experiencing and rage staffing on both shifts and 1 Nurse or MA to roon revealed with 1 NA to f 30 residents it was the residents' ADL needs and re		How the corrective action(s) monitored to ensure the pra recur: Beginning 4/18/24 the Region ADON and/or Unit Manager an audit of 3 random residentimes per week x 4 weeks the week x 8 weeks to ensure the incontinence care is being put timely. Beginning 4/18/24 the Region ADON and/or Unit Manager an audit of 3 random residentimes per week x 4 weeks the week x 8 weeks to ensure the incontinence care is being put incontinence incontinenc	onal Nurse, will complete ints per hall 5 inen 3 x per inat provided onal Nurse, will complete ints per hall 5 inen 3 x per inat		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING				27/2024	
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 037	2112024	
SURRY C	OMMINITY HEALTH CE	NTER BY HARBORVIEW		54	2 ALLRED MILL ROAD			
JUKKI C	JIMINONITI HEALIH CE	NIER BI HARBORVIEW		M	OUNT AIRY, NC 27030			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page	e 148	F 7	25				
	She stated she monit	on and staff self-scheduled. tored the schedule and either			and provided showers as scheduled.			
		to nursing staff via the on or called staff individually			Any deficient practice found during the audits will be corrected immediately an			
		ork the available shifts.			education and/or corrective action done			
	The ADON indicated	although staff			by the DON as appropriate.			
	1	were required to work a			The Avalit finaliness will be seen outed by the			
	stated recruiting new	nd days a month. She nursing staff was			The Audit findings will be reported by the DON in a Monthly QAPI meeting for a	ie		
		competed with the hospital			minimum of 3 months.			
		wage, and the patient						
	_	wer. The ADON revealed es Director was responsible			The Administrator is responsible for the execution of this plan with a compliance			
	for recruiting and hiri	•			date of 4/24/2024			
	communicated to her	the facility staffing needs for						
	hiring purposes.							
	An interview was con Nursing (DON) on 3/3 stated attracting new challenge and they chospital which paid a stated although hiring they had a good core were dependable and hours. The DON ind management team in for recruiting new sta She revealed the Hurresponsible for hiring interviews a week buinterviews a week buinterviews showed up facility had used a state however agency staff sign up to work and to scheduled shift. The	ompeted with the local higher wage. She further genew staff was a challenge egroup of current staff that divilling to work a lot of icated the nursing net daily to discuss strategies iff and retaining current staff. man Resources Director was new staff and scheduled 15 it only 3 to 4 of the scheduled p. The DON stated the affing agency in the past ff were not reliable, would then not show up for their is DON indicated she was not was having a negative effect						

AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
					(c
		345191	B. WING _		03/	27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CEN	ITER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROL DEFICIENCY)			(X5) COMPLETION DATE
F 725	An interview was cone Administrator on 03/2 Administrator indicate staff was a challenge focused on staff referreferral, sign on and referral, sign on and referral, sign on and reduce was also a focus and events weekly which breakfast or lunch, ar received a pay increastaffing challenge was effect on patient care management team provided with resident care as indicated the Human several upcoming into with newly hired nursinext week. Posted Nurse Staffing CFR(s): 483.35(g)(1) Data remust post the followind basis: (i) Facility name. (ii) The current date. (iii) The total number by the following category unlicensed nursing stresident care per shiff (A) Registered nurses (B) Licensed practical	ducted with the 2/24 at 11:17 AM. The d attracting and hiring new . She stated they were rals and were offering etention bonuses. The d retention of current staff they held staff appreciation included bringing in id all nursing staff recently se. She stated the current is not having an adverse and the nursing ovided support by assisting needed. The Administrator Resources Director had erviews scheduled along ing staff starting orientation g Information (4) Iffing Information. Equirements. The facility ing information on a daily and the actual hours worked pories of licensed and aff directly responsible for it. S. I nurses or licensed defined under State law).		732		4/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/2//2024
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 732	§483.35(g)(2) Postin (i) The facility must specified in paragra daily basis at the be (ii) Data must be po (A) Clear and reada (B) In a prominent presidents and visitor §483.35(g)(3) Public staffing data. The fawritten request, mal available to the pub exceed the commur §483.35(g)(4) Facilit requirements. The posted daily nurses 18 months, or as register. This REQUIREMEN by: Based on observatifacility failed to updainformation on each the onsite recertification. The findings included An observation made facility on 3/17/24, See the daily posted nursheet was dated 3/10. An observation of the and information sheer vecaled the sheet worth and information sheer vecaled the staffir contained the staffir	ing requirements. post the nurse staffing data ph (g)(1) of this section on a ginning of each shift. sted as follows: ble format. lace readily accessible to rs. c access to posted nurse acility must, upon oral or re nurse staffing data lic for review at a cost not to nity standard. Ity data retention facility must maintain the staffing data for a minimum of quired by State law, whichever IT is not met as evidenced ons and staff interviews, the ate the posted nurse staffing shift for 2 of 5 days during ation survey. It is de during the initial tour of the bunday, at 11:01 AM revealed se staffing and information	F 7	Immediate action(s) taken for resident(s) found to have been include: The facility failed to update the nurse staffing information on 2 of 5 days during the onsite recertification. Assistant Direcentification. Assistant Direcentification of other resident potential to be affected was a by:	ne posted each shift for ctor of at 1115 on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			03/:	27/2024	
NAME OF PR	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	217202-4	
				54	12 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CEN	NTER BY HARBORVIEW			OUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 732	and information sheel indicated the sheet had 7:00 PM shift change information that was a AM. An interview was combirector of Nursing (APM. The ADON state responsible for postin and information sheel the nurse manager or updating the posted in weekends. She indicts affing and information staffing and information staffing and information staffing and information every 24 hours and the each shift change. The aware the posted staffing highly the Unit Manage posted staffing on 3/1 she was the nurse madicated and staffing information. The Unit Manager was an interview was conformation of the Administrator on 03/2 Administrator indicated and information sheel The Administrator staffing the daily nurser indicated and information the daily nurser indic	daily posted nurse staffing ton 3/19/24 at 7:15 PM and not been updated at the and contained the same observed on 3/19/24 at 8:30 ducted with the Assistant ADON) on 3/21/24 at 12:30 and the Unit Manager was good the daily nurse staffing to Monday through Friday and the duty was responsible for information on the atted the posted nurse on sheet was changed out they were not updating it at the ADON stated she was not affing information should be too. The ADON was not sure in the ADON revealed anager on duty 3/16/24 and not to update the posted with the 1/24 at 12:38 PM. The add the posted nurse staffing to the the staffing the the staffing information and	F 7	732	All residents have the potential to be affected by the deficient practice. Actions taken/systems put into place to reduce the risk of future occurrence include: The Administrator will In-service the Director of Nursing, ADON, and Unit manager on the process of posting nursing hours and ensuring that it is posted prior to each shift by nursing management to include DON, ADON, I Wound Care Nurse and/or scheduler. Admin, DON, ADON, Unit Manager, or Scheduler will review and/or updated posting prior to shift change. Any new DONs, ADONs or Unit Manage will be in-services by the Administrator. Any agency staff will be educated prior working. How the corrective action(s) will be monitored to ensure the practice will no recur: The Administrator, Director of Nursing (DON), ADON, and/or Regional Nurse audit the Nurse Staffing posting 5 days	JM, gers to		
	daily. The Administra	m to ensure it was updated tor further stated the nurse responsible for updating			per week for 8 weeks to ensure that the numbers are posted each day as regulated.	>		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '			(X3) DATE SURVEY COMPLETED		
		345191	B. WING			1	C 27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		5	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 03/	2112024	
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 755 SS=K	the posted nurse staff on the weekends. A follow up telephone with the Administrator ind on 12-hour shifts, 7:0 PM to 7:00 AM. She staffing and informatic the morning showing changed out every 24 the posted nurse staff throughout the day to when there were call revealed the ADON a responsible for postin information sheet dail Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(§483.45 Pharmacy Srvcs/Proc Pharmaceutical services that assure the accurate services that a services that a service services that a services that a services the accurate services that a services the accurate services that a services tha	interview was conducted on 3/27/24 at 12:24 PM. icated the facility operates 0 AM to 7:00 PM and 7:00 stated the posted nurse on sheet was posted daily in both shifts and was only hours. She further stated fing sheet was updated reflect actual working hours outs. The Administrator and Unit Manager were g the nurse staffing and y. cedures/Pharmacist/Records (1)-(3)		755	Any deficient practice found during the audits will be corrected immediately an education and/or corrective action done by the Administrator as appropriate. The Audit findings will be reported by the Administrator in a Monthly QAPI meeting for a minimum of 3 months. The Administrator is responsible for the execution of this plan with a compliance date of 4/24/2024	d e ne ng	4/24/24	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/21/202-	<u>-</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			ETION
F 755	aspects of the provise the facility. §483.45(b)(2) Estably receipt and disposition sufficient detail to enterconciliation; and §483.45(b)(3) Determorder and that an action is maintained and performed that the facility of	es consultation on all ion of pharmacy services in ishes a system of records of on of all controlled drugs in able an accurate mines that drug records are in count of all controlled drugs priodically reconciled. T is not met as evidenced riew and Resident, interviews the facility failed lace for accurately receiving rolled medications from the 3/23 a possible drug diversion orted to administration by the investigation was not other residents at risk for ontrolled medications. In accy was identified between is sary reports and the in sign-out sheets for	F 7		e(s) taken for the ave been affected birector of Nursing se and VP of Clinific controlled ets by comparing eport for the last 3 enumber of apared to number art.	cal the 0	
	of 1 resident (Reside pharmacy services a effective systems the further diversion or lo medications. Immediate Jeopardy a possible drug diver	· · · ·		residents have the po affected. 3. Actions taken/sys to reduce the risk of fu include: " The facilities polic on Controlled Substar and Accountability wa 3/22/24 by the DON, A	stems put into pla uture occurrence cies and procedur nce Administration as reviewed on	es 1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED					
			A. BUILDI	NG _		١,	_
		345191	B. WING				C 27/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
	_	_		54	42 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH C	ENTER BY HARBORVIEW		М	OUNT AIRY, NC 27030		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 755	Continued From pa	age 154	F.	755			
	· ·			, 55	Worker ADON/ID Regional Nurse		
		mine if nursing staff were ms and processes for receiving			Worker, ADON/IP, Regional Nurse Consultant, Regional Operations, and	VD.	
		ntrolled medications or if			of Clinical. The VP of Clinical inservice		
		ere effective. Immediate			the participants on the Controlled	:u	
		ved on 3/23/2024 when the			Substance Administration and		
		d a credible allegation of			Accountability policy, importance of		
		y removal. The facility will			accurate reconciliation of controlled		
		oliance at a lower scope and			substances and proper procedure of		
		actual harm with a potential for			reconciling the count using the packing		
	,	s not immediate jeopardy) to			slips and/or Narcotic dispense report to		
		s completed and monitoring			ensure accurate reconciliation of		
	systems put into pla				controlled medications. This inservice		
					included the new process of including a	a	
	The findings include	ed:			Counting of Controlled medication		
					sheets/cards form will be started. Whe	n	
	1. A phone intervie	w was conducted on			new controlled medications come in fro	m	
	3/21/2024 with Nur	se #4. Nurse #4 reported she			pharmacy two nurses and/or a Nurse a	nd	
	had worked at the f	facility until October 2023. She			Med Aide enter that the sheet was adde	ed	
	reported that she w	orked as the weekend charge			and correct the count of controlled		
	nurse and worked r	mostly with Med Aides. She			medication sheets/cards. The count wi	Ш	
		to work on a Sunday in			be verified before the start of each shift	as	
		nen she was approached by			the shift- to -shift count of controlled		
		Nurse #4 a narcotic card and			medications is completed. If the count		
		neet was missing. Nurse #4			controlled sheets/cards is wrong the Do	ON	
	reported she and M				or ADON must be called and an		
		ng the medication cart and			investigation done prior to the off going		
		he missing card of narcotics			nurse leaving. The only people who car		
		gn out sheet. She reported MA			remove sheets and or discontinued me		
		port from Nurse #5 and that			or empty cards from the medication car	เร	
		n narcotic cards and narcotic			is the DON, ADON or Regional Nurse.		
	sign out sheets hor	ne in the past and ld have to call Nurse #5 to			The DON, ADON or Regional Nurse wi check all medication carts Monday	II	
		ns back to the facility. She			through Friday to remove any	ſ	
		ically Nurse #5 would say that			discontinued or completed cards and	ĺ	
		ets had got mixed up in her			sheets and sign off on the Count Sheet	,	
		did not realize it until she got			Log.		
		e #4 realized on a Sunday in			" The DON, ADON, Regional Nurse	ĺ	
		a narcotic card and narcotic			VP of Clinical on 3/22/24 began educate		
		e missing, she immediately			all Nurses and Medication Aides on the	•	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI				•	
		345191	B. WING			1	27/2024	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/2	2112027	
				54	42 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW			IOUNT AIRY, NC 27030			
(V4) ID	STIWWARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 755	Continued From pag	e 155	F	755				
		rator via telephone and text			Controlled Substance Administration a	nd		
	I .	get a response. She			Accountability policy, importance of	IG		
	_	ant Director of Nursing			accurate reconciliation of controlled			
	I .	that 'she did not have time			substances and proper procedure of			
		place a paper under her door			reconciling the count using the packing	ı		
		f on Monday morning.'			slips and/or controlled medication/narc			
		reported several times to the			dispense report to ensure accurate			
	administrative nursin	•			reconciliation of controlled medications			
		was diverting resident			The inservice included that two nurses	or		
	medications. She re	ported Nurse #5 would			a nurse and med aide will sign the			
	appear 'high at work	' would be sweating			packing slip verifying that the amount			
	profusely, cursing at	residents, and would go sit in			received from pharmacy was the amou	nt		
	her car all night.				sent, the new process of including a			
					Counting of Controlled medication			
		s timecard revealed Nurse #5			sheets/cards form will be started 3/22/2	<u>2</u> 4.		
		ay (10/22/2023) and Monday			When new controlled medications com	е		
	, ,	#5 clocked out at 8:14 am			in from pharmacy two nurses and/or a			
		nere were no further time			Nurse and Med Aide sign that the shee	t		
	entries after that date	9.			was added and correct the count of			
	A	m d- 4 m44			controlled medication sheets/cards. The			
		e was made to contact			count will be verified before the start of			
		24 at 1:00 pm, with no			each shift as the shift- to -shift count of			
	answer and there wa	is no way to leave a			controlled medications is completed. If the count of controlled sheets/cards is			
	message.				wrong the DON or ADON must be called	, d		
	Attemnts to interview	MA #2 were not successful.			and an investigation done prior to the c			
	/ (ttorripto to interview	With the word not successful.			going nurse leaving. The only people w			
	An interview was cor	nducted on 3/21/2024 at 9:21			can remove sheets and or discontinued			
		The ADON reported she was			meds or empty cards from the cart is the			
		tance when a nurse called			DON, ADON or Regional Nurse. The			
	her to report that nar	cotics were missing. The			DON, ADON or Regional Nurse will ch	eck		
	-	#5 and MA #2 had counted			all medication carts Monday through			
	medications during s				Friday to remove any discontinued or			
	,	unted MA #2 had reported			completed cards and sheets and sign of	off		
	I .	oxycontin pills (narcotic)			on the Count Sheet Log. The DON and			
	were missing that sh	ould have been in the			ADON will be responsible for keeping u	qı		
	medication cart. The	ADON stated she instructed			with who has and has not been inservi	ced		
	Nurse #5 to not leave	e the building until they could			and completing the education themselv	/es		
	find the card. She re	ported that as staff was			or assigning the Regional Nurse, Regional	onal		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
	345191	B. WING		0:	C 3/27/2024
NAME OF PROVIDER OR SUPPLIER	R	I	STREET ADDRESS, CITY, STATE, ZIP CO	•	5/21/2024
			542 ALLRED MILL ROAD		
SURRY COMMUNITY HEALTH	I CENTER BY HARBORVIEW		MOUNT AIRY, NC 27030		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR 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
sign-out sheet, Noutside to smoke exit the building, premises. The Acall Nurse #5 muto get ahold of he Corporate Nurse 10/23/2023 and to law enforcement they could not premedications. The card and the assection were never located. An interview was am with the Admereported she had narcotic sign out October 2023. See recall why Nurse reported that if die would notify the Information (DEA), police, phoffice. She reported in the ADO message from Nemedication. An interview was am with the Corporate Nurse October 2023 an medications. The recalled more pill	issing narcotic card and narcotic lurse #5 told her she was going a. Nurse #5 then proceeded to get in her car, and leave the DON stated she attempted to litiple times and was never able er. The ADON reached out to the and the Administrator on was told not to report the incident ent or the State Agency because ove that Nurse #5 had taken the e ADON reported the narcotic ociated narcotic sign out sheet	F 7:	Operations or VP of Clinical training as needed. New and Nurses and Medication Aide inserviced during orientation taking a resident assignmen " All Nurses and Medicati (MAs) will be reeducated stated by DON, ADON, Unit Manage Clinical and/or Regional Nur Controlled Substance Admin Accountability policy, importance accurate reconciliation of consubstances and proper procereconciling the count using the slips and/or controlled medical dispense report to ensure accurate and medicated that the anurse and medicated that the anurse and medicated that the anurse and medicated that the received from pharmacy was sent. When new controlled medication sheets count will be verified before each shift as the shift- to-sh controlled medications is controlled medications is controlled medications. The onlican remove sheets and or dimeds or empty cards from the DON, ADON or Regional Nurse and medication carts Monday all medication carts Monday	d/or Agency s will also be or before t. ions Aides arting 4/18/24 ger, VP of se on the histration and ance of ntrolled edure of he packing cation/narcotic ccurate hedications. wo nurses or gn the e amount se the amount medications nurses and/or that the sheet count of s/cards. The the start of hift count of mpleted. If ts/cards is ust be called rior to the off ly people who iscontinued he cart is the urse. The larse will check	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
			542 ALLRED MILL ROAD				
SURRY CO	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE
F 755	not return any phone ADON to complete a and nothing else was she did not report the or law enforcement. reported she called the replaced and had the narcotic medications, aware that both the nasign out sheet were in Nurse reported if she missing, she would henforcement, the Sta Carolina State Board. 2. Resident # 21 was 5/26/2023 with diagnord dependence and chrows a review of Resident revealed the following. An order dated 9/6/20 revealed an order for administered at bedti. An order dated 9/7/20 revealed an order for administered two times 2:00 pm) for pain. An order dated 10/31	lity, but that Nurse #5 would calls. She advised the facility wide narcotic count missing. She stated that incident to the State Agency. The Corporate Nurse he pharmacy to get the pills facility pay for the missing. She reported she was not arcotic card and narcotic missing. The Corporate had known both were ave immediately called law the Agency, and the North of Nursing (NCBON). admitted to the facility on oses which included opioid onic pain syndrome.	F 7		sheets and sign of a g. and MAs will be in a sand policies process by the D as who has not who for to the ave to do so prio will be educated a eaction(s) will be practice will not an al Nurse and/o 2024, will condure on Carts weekly so then two carts. The audit will dimedications on bunt sheets on the stice found during corrective action propriate. Will be reported QAPI meeting for responsible for a sand policies and sand process.	ON vent r to e ot r ct for	
	An order dated 11/1/2 revealed an order for	me (9:00 pm) for pain. 2023 through 12/18/2023 Methadone 30 mg to be es per day (6:00 am and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 3/27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		5/2//2024	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 755	order for Methadone three times per day (pm) for pain. A review of the pharr revealed 160 tablets Methadone 10 mg ta facility on 10/13/2023 received by MA #3. It signature acknowled delivery. A review of the narcotthe corresponding profor Resident #21 revements accounted for from the dispensary report with the top of the narcotthe top of the narcotthe top of the pharr revealed 150 tablets medication cards) of were dispensed to the Resident #21 and receipt of this deliver. A review of the narcotthe corresponding profor Resident #21 revements accounted to make the corresponding profor Resident #21 revements accounted to mg ta that were not accounted the corresponding to the corresponding profor Resident #21 revements accounted to mg ta that were not accounted the corresponding to the corresponding profor Resident #21 revements accounted to mg ta that were not accounted to mg ta that were not accounted to mg ta the table to the pharm revenue to the corresponding proformer to th	and to be administered 6:00 am, 2:00 pm, and 9:00 among to be administered 6:00 am, 2:00 pm, and 9:00 among to be administered 6:00 am, 2:00 pm, and 9:00 among the supply of a blets were dispensed to the after the among the receipt of this armacy dispensary reports a blets that were not a sign out sheet. The among the receipt of this armacy dispensary reports a blets that were not a sign out sheet. The among the among the supply for the supply for the among the supply for the suppl	F 7	55			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	' '	TE SURVEY MPLETED
		345191	B. WING_			C 3/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COL 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		312112024
(X4) ID PREFIX TAG			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	An interview was co pm with MA #3. MA longer employed at terminated approxim (2/14/2024). MA #3 including controlled pharmacy, a nurse a receive them. She receive them. She receive them. She receive them. She receive them she would sign-out sheets and and would add the sthe medication cart. discrepancies involved Methadone. MA #3 counted and signed recall an instance we staff member to signand pharmacy dispensary dispensary including reported that when refrom the pharmacy, dispensary reports to filled out the top por sheet. Nurse #2 reports the narcotic card and have the nurse/narcotic card. Nurse take controlled medication cart. An interview was co am with Nurse #3. It worked with MA #3 worked with MA #3 worked with MA #3. It worked with MA #3. It worked with MA #3. It worked with MA #3.	mducted on 3/19/2024 at 1:10 #3 reported she was no the facility and had been nately one month ago reported when medications, medications, arrived from the and a medication aide would reported the medications were put her name on the narcotic pharmacy dispensary report sheets to the narcotic book on MA #3 was not aware of any ring Resident #21's reported that she always with a nurse. She could not here she had been the only in the narcotic sign out sheets	F 7	55		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				C 27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG			ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755		armacy, two people, either	F 7	755			
	happen because ano	et after the count was d sometimes this did not ther nurse or MA could not ould have to sign and verify					
	am with the ADON. The pharmacy sends should be verified by or a MA, medications sure that the packing medication delivered, be distributed to the a The ADON reported onurses and MAs should comparing numbers of sheet. She reported issues with MA #3, the would work every day would frequently received.	ducted on 3/21/2024 at 9:21 The ADON reported when residents medications it two staff members, a nurse should be counted to make slip matches the amount of and the medications should appropriate medication cart. Oncoming and off going all did be counting cards and with the narcotic sign out there had not been any at she enjoyed working and off. She reported MA #3 sive medications, including so, from the pharmacy and had been reported.					
	pm with the Director of reported that two staff a MA, could receive repharmacy. She reported when they are nurses and med aided dispense the medical validating the medical reported nurses and marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive reported the marcotic count at shift nurses and MAs should receive receive receive receive receivers received receivers receivers received receivers received receivers receivers received receivers re	ions to the cart after					

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				27/ 2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	reviewed the narco an empty card alon sheet. The DON re narcotic sign out sheet. She verbalized sheet that the narcotic ca and checked the as sheet to ensure the reported she did no nurses, or a nurse narcotic sign out sheet to ensure the review and compare reports to the narcoverbalized she was involving Resident not aware the pharnot align with the narcotic sign out sheet was involving Resident not aware the pharnot align with the narcotic sign out sheet was involving Resident not aware the pharnot align with the narcotic sign out sheet was involving Resident mot aware the pharnot align with the narcotic sign out sheet was involving Resident mot align with the narcotic sign out sheet was involving Resident mot align with the narcotic sign out she suspected which she verbalized medication.' She as Methadone received card, card number from the 1/15/2024 identified MA #3's is signature on the ot Resident #21 for be point she suspected. An interview was compared the review monthly, ensured the review monthly, ensured the state of the properties of the properti	She reported she only tic sheets when she received g with the narcotic sign-out eported she only reviewed the neets after a medication card. It only checked to make sure rd to ensure no pills were left esociated narcotic sign out that it was zeroed out. She of always check to ensure two and an MA, were signing the neets. She verbalized did not the the pharmacy dispensary offic sign out sheets. The DON anot aware of a discrepancy #21's Methadone. She was macy dispensary reports did arcotic sign out sheets for fing the interview, the DON tic sign out sheets and the pharmacy dispensary need 16 tablets of Methadone ent #21 were not accounted for 3 pharmacy dispensary report, and would be 'a whole sleeve of 1so confirmed 25 tablets of 2so confirmed 25 tablets of 3so confirmed 25 t	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345191	B. WING		03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 00/21/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 755	randomly audited apsheets monthly whe Pharmacist reported narcotic sign out-she the medication cart. validate narcotic sig reports from the phasuspected diversion conversation with nu facility. The Pharma aware of any missin running out of Resid. An interview was coam with the Corpora Nurse reported the ADON controlled medication involve MA #3. The recall any complaint residents, including their medications. Sknown the facility to they did communicate pharmacy about Me. An interview was coam with the Administ not been notified of possible diversion in substances. The Adwas terminated on 2 working more hours and became upset we reported MA #3 had	n orders, etc. He reported he oproximately three narcotic in he visited the facility. The inhe strictly looked at the eet and medication card on He reported he did not in out sheets with discrepancy armacy. He verbalized if he that he would have had a ursing management in the acist did not recall being made in gnarcotics or the facility ent #21's Methadone. Inducted on 3/21/2024 at 9:45 at Nurse. The Corporate ADON would call her with DON was on leave. She had called to report missing ins, but the situation did not Corporate Nurse did not is about MA #3 or about Resident #21, not receiving the reported she had never run out of Methadone but the back and forth with the thadone at one point. Inducted on 3/21/2024 at 9:41 trator. The Administrator had missing medications or	F 75	5		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CEI	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From page	e 163	F7	755			
	The Administrator wa Jeopardy on 3/21/202	s notified of Immediate 24 at 6:25 pm.					
	The facility provided tallegation of Immedia	he following credible te Jeopardy Removal:					
		oients who have suffered, or serious adverse outcome ompliance:					
	revealed the facility far procedures and have accurately receiving a medications. Nurse at (MA) #2 had approact on night shift and repmissing along with the after MA #2 had rece Nurse #4 notified the Director of Nursing (Anarcotics immediately Resident #21's contror revealed a discrepant dispensary report and record sheets.	and reconciling controlled #4 stated Medication Aide hed her in October of 2023 orted that narcotics were en arcotic sign out sheet ived report from Nurse #5. Administrator and Assistant ADON) of the missing y. In addition, a review of olled medications records cy in the pharmacy dithe controlled/narcotic					
	audit of controlled me comparing the pharm last 30 days compare controlled sheets con medications on the cabe investigated and r Licensing board and	VP of Clinical completed an edication count sheets by acy dispense report for the ed to the number of art. Any issues, if found, will eported to the State authorities per policy.					
		the entity will take to alter the ilure to prevent a serious					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING				C 27/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	03/	27/2024
	_	_		542 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH	CENTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 755	when the action will The facility's policie "Controlled Substate Accountability" was DON, Administrate Regional Nurse Co and VP of Clinical. the participants on Administration and importance of accusubstances and property the count using the dispense report to of controlled medic included the new property of controlled medic included the new	from occurring or recurring, and ill be complete: es and procedures on ance Administration and a reviewed on 3/22/24 by the procedures on ance Administration and a reviewed on 3/22/24 by the procedure of ADON/IP, consultant, Regional Operations, The VP of Clinical in-serviced the Controlled Substance and Accountability policy, contract reconciliation of controlled oper procedure of reconciling espacking slips and/or Narcotic ensure accurate reconciliation cations. This in-service process of including a Counting cation sheets/cards form will new controlled medications macy two nurses and/or a deenter that the sheet was the count of controlled /cards. The count will be start of each shift as the shift-portrolled medications is count of controlled ong the DON or ADON must be estigation done prior to the off g. The only people who can dor discontinued meds or the medication carts are the regional Nurse. The DON, I Nurse will check all fonday through Friday to ontinued or completed cards and if on the Count Sheet Log.	F 7	755			
		Regional Nurse, VP of Clinical educating all Nurses and					

	O I OIL WEDION ILE G	THE BIOTUS CENTRICES					. 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILD	inG _			0
		345191	B. WING				27/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SURRY CO	OMMIINITY HEALTH CE	NTER BY HARBORVIEW		5	42 ALLRED MILL ROAD		
30111111	OMMONTT TILALITI GLI	NIEK BI HARBOKVIEW		N	MOUNT AIRY, NC 27030		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
17.0		,			DEFICIENCY)		
F 755	Continued From page	e 165	F	755			
		the Controlled Substance					
	Administration and A						
		te reconciliation of controlled					
		er procedure of reconciling					
	the count using the p	• .					
	I .	/narcotic dispense report to					
		nciliation of controlled					
	medications. The in-service included that two nurses or a nurse and med aide will sign the						
	packing slip verifying from pharmacy was t						
	process of including a						
	_	rds form will be started					
		controlled medications come					
		nurses and/or a Nurse and					
		e sheet was added and					
	correct the count of c						
	sheets/cards. The co	ount will be verified before					
	the start of each shift	as the shift- to -shift count					
	of controlled medicat	ions is completed. If the					
	count of controlled sh	neets/cards is wrong the					
	DON or ADON must						
		ior to the off going nurse					
		ople who can remove sheets					
		neds or empty cards from					
		, ADON or Regional Nurse.					
		Regional Nurse will check all					
		nday through Friday to					
		nued or completed cards and					
	_	n the Count Sheet Log. The					
	DON and/or ADON w	who have and has not					
		completing the education					
		ing the Regional Nurse,					
		or VP of Clinical to assist					
		ed. New and/or Agency					
	Nurses and Medication	- ·					
		entation or before taking a					
	resident assignment.						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CE	NTER BY HARBORVIEW		STREET ADDRESS, CITY, 542 ALLRED MILL ROA MOUNT AIRY, NC 27	AD.	USIZ112024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	
F 755	Continued From page	e 166	F7	755		
	begin the process of controlled medication matches the amount the cart Monday thro pharmacy dispense r medications card cou					
		ility's immediate jeopardy				
	removal plan was val and interviews:	lidated through record review				
	Nurse, and VP of clir controlled medication comparing the pharm last thirty days. The procedures on Control Administration and A on 3/22/24 by the Ad Social worker, region Regional Operations staff interviews and resheets revealed nurse education on the Cor Administration and A pharmacy. Inservice included the new pro	nacy dispense report for the facilities policies and olled Substance ccountability was reviewed ministrator, DON ADON, all Nurse Consultant, and VP of Clinical. Nursing eview of in-service sign in ing staff had received introlled Substance ccountability Policy regarding a provided to the staff				
	form will be started, to medication aid enter and corrected. This were completed by reaware that only the Diremoved control card	wo nurses or nurse and that the sheet was added was verified that the checks ecord review. Staff was OON and ADON are able ds from carts and verified that were being completed				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345191	B. WING _		C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	, 33,21,2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 755	and medication aids receiving training on medication. Interview medication aids reveareceiving training on medication. Administrevealed they had conurses and medicationshift.	ay. Interview with the nurses revealed they acknowledge Counting of controlled with the nurses and aled they acknowledge Counting of controlled	F 7	55	
F 760 SS=D	CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Residen medication errors. This REQUIREMENT by: Based on staff intervinterview, and record prevent a significant in Medication Aide #1 a not administer medica (Resident #98) review medication errors. The findings included Resident #98 was ad 2/15/24 with diagnose dementia with agitatic disorder, disorder of a	is not met as evidenced iews, Medical Director review, the facility failed to medication error when nd Medication Aide #4 did ations for 1 of 1 resident wed for significant : mitted to the facility on es which included severe on, bipolar disorder, anxiety adult personality and and hemiparesis following	F 7	1. Immediate action(s) taken for resident(s) found to have been affer include: "Resident # 98 failed to receive medications as ordered. Resident had medications that were held. Medication aides # one and four difollow the proper procedures to how medications. Resident #98 no long resides in the facility. Director of Niprovided education to Medication A one and four on 3/22/24 as to the procedure of holding medications. notified 3/22/24. 2. Identification of other residents the potential to be affected was accomplished by:	ected # 98 d not Id er ursing Aides #s MD

PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			1	C 27/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112024	
					42 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW			MOUNT AIRY, NC 27030			
240.15	CLIMANA DV CT	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X				
F 760	(MDS) dated 2/22/24 cognitively intact, with and inattentive behaviorevealed Resident #9 and verbal behaviors other behaviors not diphysical behaviors diverbal/vocal symptom	sion Minimum Data Set revealed Resident #98 was a delirium sign/symptoms, riors. The MDS further 8 was coded for physical directed toward others, and irected toward others (i.e., rected toward self or as like screaming). The MDS	F 7	760	 " All residents have the potential to affected by this deficient practice. 3. Actions taken/systems put into pla to reduce the risk of future occurrence include: " The Director of Nursing, Assistant Director of Nursing, Unit Manager, VP Clinical and/or Regional Nurse, beginn 4/18/2024, will educate all Nurses and Medication aides on the proper proced 	of ing I ure		
	verbal/vocal symptoms like screaming). The MDS indicated the residents' behaviors put the resident at significant risk for physical injury and put others at significant risk of physical injury. The MDS revealed Resident #98 had rejection of care behaviors. She was coded on the MDS for receiving antianxiety. She was not coded on the MDS for receiving antipsychotic medication. 1a) Record review of active medications revealed an order dated 3/5/24 that read Xanax (antianxiety medication) Oral Tablet 0.5 Milligrams (MG) (Alprazolam), give 1 tablet by mouth three times a day for anxiety hold for sedation. The Medication Administration Record (MAR) for March 2024 revealed Xanax had not been administered as ordered for 8:00 AM scheduled dose on 3/16/24 by Medication Aide #4. The medication was marked on the MAR by Medication Aide #4 as not administered on 3/16/24 due to resident sleeping. 1b) Record review of active medications revealed an order dated 3/6/24 that read, Nuedexta (used for neurological condition) Oral Capsule 20-10 MG (Dextromethorphan HBr-Quinidine Sulfate), give 1 capsule by mouth two times a day for yelling				of holding medications, notification of Mand documentation. " All new RNs, Medication Aides an LPNs will be in serviced on these items during the orientation process by the Dor ADON. " Any RNs, MAs, LPNs who have now went through the training prior to the compliance date will have to do so prioworking again. " All Agency staff will be educated p to working	MD d s OON ot or to		
					4. How the corrective action(s) will be monitored to ensure the practice will no recur: " The Director of Nursing (DON), ADON and/or Regional Nurse, beginni 4/18/2024, will review all medications were held 5 days per week for 12 weel to ensure the proper procedure, notifications and documentation were done for holding the medications. " Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the DON as appropriate. " The Audit findings will be reported.	ng that ks		

Facility ID: 953479

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345191	B. WING _			1	C 27/2024
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112024
					542 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW			MOUNT AIRY, NC 27030		
				- '	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 760	Continued From page	e 169	F				
	and crying.				the DON in a Monthly QAPI meeting for minimum of 3 months.	or a	
	The Medication Admi	nistration Record (MAR) for					
		Neudexta had not been			5. The Administrator is responsible for	the	
	administered in the m	orning as ordered on			execution of this plan with a compliance		
	3/16/24, 3/17/24 by M	Nedication Aide #4. The			date of 4/24/2024		
		ed as not administered on					
		on Aide #4 for the reason					
	resident sleeping.						
	10)						
	1c)	ve medications revealed an					
	order dated 3/16/24 ti						
		ation) Oral Tablet 25 (MG)					
		e), give 25 mg by mouth one					
	time a day related to						
	March 2024 revealed administered daily (in the following days: 3/ Medication was mark	ed on the MAR by s not administered due to					
	An interview was north	formed on 02/17/24 at 04:22					
	-	formed on 03/17/24 at 04:23 Nide #4. She said Resident					
		elled when she was awake.					
		eceived a shift change report					
		orning (3/17/24), that					
		en awake and screaming					
		plained Resident #98 had					
		ning medications today					
		y (3/16/24) because she "did					
	, , ,	d idea to wake her up". She					
	_	would go back and try to					
		ns once Resident #98 woke					
	up but had gotten bus	sy and forgotten. She					
		a manager on duty present					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024		
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZI 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	P CODE	03/21/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		DATE		
F 760	questions about med needed to be assess. A follow-up interview Medication Aide #4. had notified the Assis (ADON) on Saturday given Resident #98 h She stated she did n 3/17/24. An interview was per AM with Nurse #7. Saides could not make medications. She stated and you definitely ne notify them if medicatexplained if a resider respect their sleep, be scheduled medication before/ after time fraithe medications. Nur medication, such as medication) could im later in the day if it we A telephone interview at 12:40 PM with the She said Resident #5 behaviors. She explained #98 and made sever	there was always a ne building if she had lications, or if a resident ned. was completed with She said she thought she stant Director of Nursing (3/16/24) that she had not ner morning medications. The or notify anyone on Sunday formed on 3/22/24 at 11:20 he explained that medication the decision to hold need to contact the doctor to tions had been held". She not was sleeping, she tried to not would try to administer nes to them within an hour me of the scheduled time of se #7 said she thought a Seroquel (antipsychotic pact a resident's behaviors as not administered. We was performed on 3/21/24 Physician Assistant (PA). Physician Assistant (PA) and the property of the scheduled time of the scheduled time of se #7 said she thought a Seroquel (antipsychotic pact a resident's behaviors as not administered.	F7	760				
	morning medications PA was asked if Res	t received her scheduled on 3/16/24 or 3/17/24. The ident #98's medications e to be administered when						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024		
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		03/2//2024		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE		
F 760	, ,	Continued From page 171 she awoke at 11:30 AM, the PA stated she		760				
	requested to be notilate. The PA said Rescheduled psychotronic Seroquel and Xanax	fied if medications were that esident #98 not receiving her opic medications, such as a in the morning on 3/16/24 cause her behaviors to be dications should be						
	Director of Nursing AM. She explained next to the medicati for assessments, mand administered in had been the mana 3/17/24 and was the Medication Aide #4 medication aides cohold medications shassessment by the make the decision. Order to hold medication order to hold medication there. The ADON sain the morning staff resident up to give the said Medication Aide 3/16/24 that Reside morning medication would not take them to take them. The Ago back and try again a resident refused to	erformed with Assistant (ADON) on 3/22/24 at 10:00 the nurse assigned on the hall on aide would follow the hall edications, falls, questions, sulin. The ADON stated she ger on duty on 3/16/24 and e nurse who had followed on B hall. She explained uld not make the decision to e stated, that required an nurse and the nurse would She said that there was an ations if the physician was not aid, if a resident was sleeping should still try to wake the hem their medication. She e #4 had notified her on nt #98 had not received her s. She stated Resident #98 n, that she would not wake up DON explained staff should in to administer medications if nem. She said she was not ide #4 did not wake Resident						
	because Resident # yelling. The ADON s #98 had been up ur	ngs to give her medications, 98 would start screaming/ said she was aware Resident til 4:00 AM the night of yelling. She explained she						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	_	(X3) DATE COMP	SURVEY LETED
		345191	B. WING _		_		27/ 2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	1 03/2	2112024
				542 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 2703	30		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG				(X5) COMPLETION DATE
F 760	Continued From page	e 172	F7	60			
F 700	had thought Medicati Resident #98 her me because she could not them. She said she as because she had because s	on Aide #4 had not given dications on 3/16/24 of get her awake to take ssumed it had been en up all night. The ADON y why Medication Aide #4 e Resident #98 her e awoke on 3/16/24 or e physician was not notified that Resident # 98 had not medications. The ADON did not receive her ions in the morning it could during the day and cause formed on 3/22/24 with the DON) at 11:38 AM. She said would usually talk to the stions about medication, needed to be assessed. She was resting and sleeping she up to give medications. When a not receiving her morning ions would impact her, her situation was difficult to he would want staff to edications when Resident is unaware they were not stated on Sunday 3/17/24 and "for 5 hours", and they er and gotten an order to extra dose of Xanax and he did not think the liministered as ordered would ent #98's behaviors.		60			
	would not wake her uasked if Resident #98 psychotropic medical behaviors she stated say. The DON said sattempt to give the m#98 woke up and warprovided. The DON sResident #98 scream had called the provid give Resident #98 and Seroquel. She said smedications being achave impacted Resident An Interview was per	p to give medications. When B not receiving her morning ions would impact her, her situation was difficult to he would want staff to edications when Resident sunaware they were not stated on Sunday 3/17/24 led "for 5 hours", and they er and gotten an order to extra dose of Xanax and he did not think the lministered as ordered would					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C /27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW]	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	03	/27/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 761 SS=D	"sedating medication expect medications awake and alert. She the scheduled time of call the physician and to do with medication Medication Aides comedications. She saif the Medication Aiden nurse if they held mesaid she thought it womedication aide to not then check with the state to them. She said she did not go back and #98 once she awoke forgot. The Administicall hospice on 3/17/extra dose of Xanax was yelling/screami Label/Store Drugs at CFR(s): 483.45(g)(h) §483.45(g) Labeling Drugs and biological labeled in accordance professional principle appropriate accessoon instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accessional laws, the fact biologicals in locked	Resident #98 up to give her as". She explained she would to be given if a resident was a said, if this was later than of the medication, she would d ask what he wanted them as. The Administrator stated all make the decision to hold id she would have to look at a enceded to check with a edications. The Administrator rould be okay for the cot give the medication and anurse later when they talked are thought Medication Aide #4 offer medications to Resident and are stated nursing had to (24 to get Resident #98 and and Seroquel because she and Biologicals (1)(1)(2) of Drugs and Biologicals as used in the facility must be see with currently accepted ess, and include the	F 7			4/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	' '	ATE SURVEY OMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		<u> </u>
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 761	locked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distrik quantity stored is mide readily detected. This REQUIREMEN by: Based on observatic containing medication carts) obstorage. The findings include a. During a continue 11:01 AM to 11:04 Amedication cart was lock protruding and 11:02 AM Nurse #6 cart, retrieved an ite walked away from the medication cart unlowed the unlocked medication cart unlowed the unlocked medication. An interview was co 3/17/24 at 4:19 PM. needed something.	acility must provide separately affixed compartments for a drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit oution systems in which the nimal and a missing dose can T is not met as evidenced ons and staff interviews, carts ons were left unlocked and 4 carts (A and C Hall oserved for medication	F 7	1. Immediate action(s) taker resident(s) found to have bee include: "Facility left unlocked and 2 of 4 medication carts. Direct Nursing provided in servicing hall medication nurses on 3/1 regarding ensuring that the m cart was locked at all times what use. 2. Identification of other resist he potential to be affected was accomplished by: "All residents have the potential to be affected was accomplished by: "All residents have the potential to be affected was accomplished by: "All residents have the potential to be affected was accomplished by: "The DON, Assistant DON Clinical, Unit Manager and/or Nurse beginning 4/18/2024, NRNs, LPNs and Medication Airseland in Airse	unattended tor of to the A & C 7/24 ledication hen not in lidents having as tential to be eft unlocked lut into place currence lidents will inservice	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345191	B. WING _			03/2	27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 761	lock it. Nurse #6 expl keep the medication including residents, overbalized he though resident to be able to the cart if it was unlooked. A continuous obset 3/17/24 from 11:10 A (C hall) medication caby the lock protruding unattended. There we observed in the hallw member. Nurse #1 recart and locked the cart and locked the cart and locked the cart. She stated it unlocked it would be staff to open the cart. the cart unlocked couwere a lot of medicat why there was a locked. The 300-hall (C hards observed on 3/17/24 be unlocked as evide and the cart was unaresident who was observed on are the medication cart. Nurse for the medication cart to the medication cart	n cart but had forgotten to ained it was important to cart locked so no one, ould get into the cart. He tit was possible for a pull on the cart and open cked. ervation was conducted on M to 11:14 AM. The 300-hall art was observed unlocked grand the cart was ere two mobile residents and, along with a staff eturned to the medication art at 11:14 AM. formed with Nurse #1 on She stated she did not edication unlocked. Nurse #1 estracted and forgot to lock of the medication cart was possible for residents and Nurse #1 explained leaving all be bad and said there ions in the cart, and that was	F	761	at all times when not in use and unattended. "All new RNs, Medication Aides and LPNs will be in serviced on these items during the orientation process by the D or ADON. "Any Staff who have not went throu the training prior to the compliance date will have to do so prior to working again "Any agency staff will be educated prior to working 4. How the corrective action(s) will be monitored to ensure the practice will no recur: "The Director of Nursing (DON), ADON and/or Regional Nurse, beginnin 4/18/2024, will audit all medication car once per day, 5 days per week for 12 weeks to ensure all carts are locked as appropriate. "Any deficient practice found during the audits will be corrected immediately and education and/or corrective action done by the DON as appropriate. "The Audit findings will be reported the DON in a Monthly QAPI meeting for minimum of 3 months. 5. The Administrator is responsible for execution of this plan with a compliance date of 4/24/2024.	on o	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345191	B. WING		C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	00/21/2024
(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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLÉTION
F 761 Continued From pa		ne 176	F 76	31	
	her return to the med	_			
	She stated the medi- should remain locker nurse left the cart, th stated she could not have happened beca	Director of Nursing (DON). cation and treatment carts d. The DON explained if a ney should lock the cart. She elaborate on what could hause of the carts being I "you just never know."			
F 842 SS=D	PM with the Adminis walked away from the cart. She stated if the a resident or staff was opened the cart draw medications in the caspeak to why the call Resident Records -	dentifiable Information	F 84	12	4/24/24
	(i) A facility may not resident-identifiable (ii) The facility may r resident-identifiable accordance with a cagrees not to use or	elease information that is			
	, , , ,	ecords. ordance with accepted ds and practices, the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345191	B. WING			C 3/27/2024		
NAME OF P	ROVIDER OR SUPPLIER	1 0.0.0.		STREET ADDRESS, CITY, STATE, ZIP COD		3/2//2024		
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		542 ALLRED MILL ROAD MOUNT AIRY, NC 27030				
(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 ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 842	that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The facall information contairegardless of the forrecords, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, particular operations, as perminimith 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement purpurposes, research purpurposes,	al records on each resident nented; le; and ganized cility must keep confidential ned in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; syment, or health care tted by and in compliance s; activities, reporting of abuse, violence, health oversight d administrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or Il records must be retained e required by State law; or ne date of discharge when ent in State law; or ars after a resident reaches	F8	42				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345191	B. WING _			03/	27/ 2024
NAME OF P	ROVIDER OR SUPPLIER	1 1 1		STREET ADDRESS, CITY, STATE, ZIP CODE		1 03/2	2112024
				542 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 842	1 3		F 8	42			
	(i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review of determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMENT by: Based on record rev Director interviews, the accurate medical record	icted by the State; i's, and other licensed iss notes; and logy and other diagnostic equired under §483.50. is not met as evidenced iew, staff and Medical ne facility failed to maintain ords related to intravenous ents reviewed for hydration		Immediate action(s) taken resident(s) found to have been include: The facility failed to maintamedical records related to intrafluids for resident #255. Reside longer resides in the facility.	n affected ain accur avenous	rate	
	Resident #255 was to saline intravenous int milliliters per hour (m day and night shift as of 3 days. A Medication Adminis February 2024 revea normal saline intrave liters for a duration of revealed Medication Resident #255 receiv on the 7:00 AM to 3:07:00 AM shift. Nurse	A/hr) x 2 liters of fluid every a a supplement for a duration stration Record dated led an order for 0.45% hous infusion at 85ml/hr x 2 3 days. The documentation Aide #5 initialed the MAR as ed the infusion on 03/01/24 00 PM shift and 11:00 PM to #6 initialed the MAR as to receive the infusion on		2. Identification of other residence the potential to be affected was accomplished by: " All residents who have interested to be a this deficient practice. 3. Actions taken/systems put to reduce the risk of future occinclude: " The Director of Nursing, A DON, VP of Clinical, Unit Mana Regional Nurse, beginning 4/1 will inservice RNs and LPNs of facilities Intravenous Therapy pensuring that all residents with IV therapy receive their IV therand as ordered per the physici	ravenous affected I t into place currence assistant ager and 18/2024, n the policy and orders for	s by ce /or d or	

0	C . C	MEDIO/ (ID CEITVICE)					. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			20.25"			(2
		345191	B. WING _				27/2024
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE		
OUDDY O	OMMUNUTY HE ALTH OF	NITED DV I A DD ODVIEW		54	42 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CE	VIER BY HARBORVIEW		М	OUNT AIRY, NC 27030		
(X4) ID	_	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 842	Continued From page 179			842			
	03/03/24 for the 7:00				inservice will also cover ensuring that		
	00/00/24 101 110 7:00	to 0.00 FW SIME.			accurate documentation is completed l	οv	
	An interview conduct	ed on 03/27/24 at 11:27 AM			the RN or LPN regarding IV therapy.	- 7	
	with Unit Manager #1	revealed she had entered			" All new RNs and LPNs will be in		
	the physician order da	ated 02/29/24 for			serviced on these items and policies		
	` ′	s for Resident #255. The			during the orientation process by the D	ON	
		e would have normally			or ADON.	_	
started the IV herself, however it was a busy day				" Any Staff who have not went throu			
and she didn't get to it. She stated the supplemental fluids were ordered by the physician because the resident had a decrease in				the training prior to the compliance dat will have to do so prior to working agai			
				" Any agency staff will be educated	11.		
	' '	experiencing a decline. She			prior to working		
		arge of the resident's hall on			prior to working		
		let the oncoming nurse			4. How the corrective action(s) will be	е	
		needed an IV started. The			monitored to ensure the practice will no		
	interview revealed sh	e received a call from Nurse			recur:		
		asked if Resident #255 had			" The Director of Nursing (DON),		
		vere his fluids completed.			ADON and/or Regional Nurse, beginni		
		ot know the answer to that			/18/2024, will review all intravenous flu		
	-	y would have to investigate			orders 5 days per week for 12 weeks to		
		he interview revealed she 03/04/24 that Resident			ensure all orders for intravenous fluids implemented as ordered and	are	
	1	never been initiated as			documentation is completed accurately	,	
	1 11 11 11 11 11 11 11 11 11 11 11 11 1	ty contacted Emergency			" Any deficient practice found during		
		MS) to come and start a IV			the audits will be corrected immediatel		
	,	stated she did not know why			and education and/or corrective action	-	
	Medication Aide #5 d	ocumented the resident had			done by the DON as appropriate.		
	an IV because he did	not.			" The Audit findings will be reported		
					the DON in a Monthly QAPI meeting for	ra	
		empted with Medication Aide			minimum of 3 months.		
		:50 AM, 2:13 PM and 3:34			F. The Administrator is recognible for	tho	
	PM with no return pho	Jue can received.			5. The Administrator is responsible for execution of this plan with	u I C	
	An interview conductor	ed on 03/27/24 at 11:56 AM			a compliance date of 4/24/2024.	ĺ	
		ursing (DON) revealed a			2 2011phanes date of 1/27/2027.		
		ame to her on 03/04/24 and				ĺ	
		was supposed to have IV				ĺ	
		e stated she immediately				ĺ	
	asked Nurse #11 to s	start the IV. She stated once					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	<u>'</u>	33/2//2024
(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 842	she reviewed Reside Medication Aide #5 w had IV fluids and she The DON stated Nurs an IV when he realize one.	nt #255's MAR she spoke to tho stated the resident never had documented in error. se #6 should have initiated ed the resident did not have	F 8			
F 867 SS=F	monitoring. A facility must establi policies and procedure collections systems, adverse event monitor procedures must include following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representation information will be used are high risk, high voopportunities for imprevalent formation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify, coinformation from all donot limited to the facility systems to identify the fac	reedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the maintenance of effective duse of feedback and input other staff, residents, and res, including how such ed to identify problems that tume, or problem-prone, and overnent. I maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance. I development, monitoring, formance indicators, ology and frequency for such	F 8	367		4/24/24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZII 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	PCODE	03/2//2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 867	including the method systematically identificantly and use data adverse events in the facility will use the daprevent adverse events adverse events in the facility will use the daprevent adverse events and track performance and track performance implementing those and track performance improvements are results. The facility will be designed to elevel to prevent qualisafety problems; and (iii) How the facility will have the	y adverse event monitoring, its by which the facility will fy, report, track, investigate, a and information relating to be facility, including how the lata to develop activities to ents. systematic analysis and see improvement and, after actions, measure its success, ace to ensure that realized and sustained. Incility will develop and didressing: In a systematic approach to great causes of problems tems; are lop corrective actions that affect change at the systems are ity of care, quality of life, or it will monitor the effectiveness approvement activities to ments are sustained.	F	367		
	performance improve high-risk, high-volum consider the incidence	acility must set priorities for its ement activities that focus on ne, or problem-prone areas; ce, prevalence, and severity areas; and affect health				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		3012112024
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F 867	substitution of the section of this section. The section of	safety, resident autonomy, diquality of care. Immance improvement a medical errors and adverse alyze their causes, and we actions and mechanisms ock and learning throughout the art of their performance ies, the facility must conduct to improvement projects. The necy of improvement projects acility must reflect the scope me facility's services and a serification at §483.70(e). The necy of improvement projects acility must reflect the scope me facility's services and a serification at least neat focuses on high risk or as identified through the data was described in paragraphs	F	367		
	(iii) Regularly reviev	entified quality deficiencies; v and analyze data, including r the QAPI program and data				

<u> </u>	or or medicine a	T CERTIFICATION OF THE SERVICE OF TH				<u> </u>	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,	CONTRACTION	BENTI IO/MIGNIBER	A. BUILDI	NG _			
		345191	B. WING				27/2024
NAME OF PI	ROVIDER OR SUPPLIER	0.0.01			TREET ADDRESS, CITY, STATE, ZIP CODE	03/	2112024
					42 ALLRED MILL ROAD		
SURRY C	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		M	OUNT AIRY, NC 27030		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 867	Continued From page	e 183	F	867			
	resulting from drug re	egimen reviews, and act on					
	available data to mak	ce improvements.					
		「 is not met as evidenced					
	by:	iew and staff interviews the			1 Immediate action(a) taken for the		
		ssment and Assurance			 Immediate action(s) taken for the resident(s) found to have been affected 	1	
		ed to maintain implemented			include:	•	
	procedures and moni				" Corrective action will be accomplis	hed	
		to place following the			for the repeat deficiencies that included		
	recertification survey and complaint investigation on 12/01/2022. The failure included five deficiencies that were originally cited in the areas				F600 Free from Abuse and Neglect, F6		
					Developing/Implementing Abuse/Negle		
	of Free from Abuse a	- ·			Policies, F641 Accuracy of Assessmen F692 Nutrition/Hydration Status	is,	
		nting Abuse/Neglect Policies			Maintenance, F725 Sufficient Nurse		
	(F607), Accuracy of A	-			Staffing, F755 Pharmacy Services and		
		tatus Maintenance (F692),			Procedures, F760 Significant Medication	วท	
		ing (F725), Pharmacy			Error		
		ures (F755), and Significant			0		
	recited on the current	760) that were subsequently			Identification of other residents have the potential to be affected was	ving	
		on on 3/27/2024. The repeat			accomplished by:		
		vo federal surveys of record			" All residents have the potential to	be	
	showed a pattern of t	he facility's inability to			affected by this practice.		
	sustain an effective C	QA program.			Actions taken/systems put into pla	ce	
	The findings included	ŀ			to reduce the risk of future occurrence include:		
	gg-	-			" The facility held Adhoc Quality		
	This tag is cross refe	rred to:			assurance process improvement (QAP		
					meeting with the committee on 4/16/24		
		rd review, staff and Medical			develop the plan for improvement in the	ese	
		ne facility neglected to norder for intravenous fluids			5 areas. The committee will include additional licensed nurses and corpora	to	
	for 1 of 3 residents re				support (Regional Nurse Consultant,		
	(Resident #255).				Regional Director of Operations) in the		
	,				discussion for the improvement plan. T		
		tion and complaint survey of			facility utilizes the Quality Improvement	t	
		y failed to ensure a resident			Organization (QIO) for additional trainir	ng	
		t when it failed to provide the			and resources.	[
	∣ care atter requested t	for 1 of 1 sampled resident			" Measures put into place to ensure		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345191	B. WING _			1	27/ 2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2024
				5	42 ALLRED MILL ROAD		
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		N	OUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	e 184	F 8	367			
	episode of vomiting at F607: Based on reconsisterviews the facility abuse, neglect, and eareas of protection, reallegations of abusive toward residents. On (MA) #1 and Nurse A #98 and Resident #30 and on 3/12/24 Nurse physical restraint for I required to treat the resymptoms. Following NA #1 were allowed to care resident assigning facility failed to invest report the allegations enforcement, and Add deficient practice was residents reviewed for	rd review and staff failed to implement their exploitation policy in the exporting, and investigating e actions perpetrated by staff 3/10/24 Medication Aide ide (NA) #2 placed Resident 05 in involuntary seclusion e Aide (NA) #1 utilized a Resident #15 that was not esident's medical the incidents, MA #1 and o continue working direct ments. Additionally, the igate the allegations and to to the state agency, law ult Protective Services. The			that the deficient practice will not recurbe the QAPI committee will meet twice monthly for three months with the additional meeting focusing on the 5 repeat deficiencies. 4. How the corrective action(s) will be monitored to ensure the practice will not recur: " The facility will monitor its performance to ensure the solutions are sustained by discussing in detail the results of the audits twice monthly at the QAPI meeting with attention noted to the repeat deficiencies for 3 months. The QAPI plan will be adjusted according to the results and success of the plans implemented. 5. 1. The Administrator is responsified the execution of this plan with a compliance date of 4/24/2024.	e ot e e ne ne	
	12/01/2022 the facility abuse and neglect po by failing to report an	tion and complaint survey of y failed to implement their olicy in the area of reporting allegation of neglect to after the allegation was er for 1 of 1 resident.					
		failed to accurately ge Minimum Data Set (MDS) resident reviewed for					
	During the recertificat	tion and complaint survey of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP 6 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	CODE	00/E1/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 867	an annual MDS asselevel 2 Preadmission Review (PASRR) for PASRR. F692: Based on recording physician order for #255). The deficient sampled residents for During the recertifica 12/01/2022 the facili implement nutritional by the Registered Disignificant weight lost for 1 of 6 residents resident and staff interprovide sufficient nutresident's preference residents (Resident to provide baths, shot to dependent resident Resident #59, and Reviewed for sufficient During the recertifica 12/01/2022 the facili nurse staffing to provide provide provide sufficient nutresident #59, and Reviewed for sufficient During the recertifica 12/01/2022 the facili nurse staffing to provide parts.	ty failed to accurately code essment for the presence of a a Screening and Resident of 2 residents reviewed for ord review, staff and Medical the facility failed to implement intravenous fluids (Resident practice was for 1 of 3 or review of hydration. Ation and complaint survey of the failed to carry out and a linterventions recommended etician for a resident with the staff for a hospitalization reviewed for nutrition. Ford review, observations, erviews, the facility failed to resing staff to honor a se for showers for 2 of 4 the failed to failed to the facility failed to resing staff to honor a se for showers for 2 of 4 the failed to fail the failed to fail the failed to fail the fail the failed to fail the fai	F	367		
	Pharmacist and staft to have systems in p	ord review and Resident, interviews the facility failed lace for accurately receiving rolled medications from the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
345191 B	B. WING _		C 03/27/2024	
NAME OF PROVIDER OR SUPPLIER SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	03/21/2024	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
pharmacy. On 10/23/23 a possible drug diversion by Nurse #5 was reported to administration by Nurse #4. An effective investigation was not conducted which put other residents at risk for loss or diversion of controlled medications. In addition, a discrepancy was identified between the pharmacy dispensary reports and the controlled medication sign-out sheets for Resident #21's Methadone received by Medication Aide (MA) #3 on 10/13/23 and 1/16/24. The deficient practice was identified for 1 of 1 resident (Resident #21) reviewed for pharmacy services and due to the lack of effective systems there was a high likelihood of further diversion or loss of resident's-controlled medications. During the recertification and complaint survey of 12/01/2022 the facility failed to have an effective system in place to ensure staff did not have to borrow controlled substance medications from 3 of 3 residents to give to other residents whose medications were not available in the facility on 3 of 4 hallways and failed to administer a physician ordered medication for 1 of 1 resident reviewed for psychotropic medications. F760: Based on staff interviews, Medical Director interview, and record review, the facility failed to prevent a significant medication error when Medication Aide #1 and Medication Aide #4 did not administer medications for 1 of 1 resident (Resident #88) reviewed for significant medication errors. During the recertification and complaint survey of 12/01/2022 the facility failed to prevent a significant medication error when they failed to obtain and administer a sleeping medication as	F 8	67		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NI IMBED		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						С
		345191	B. WING _			03/27/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, O	CITY, STATE, ZIP CODE	
CUDDY C	OMMUNITY LIEALTH CE	NTED BY HADDODVIEW		542 ALLRED MILL F	ROAD	
SURRIC	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NO	27030	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	IVIDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 867	Continued From pag	e 187	F 8	67		
	ordered by the Physi reviewed for medical	cian for 1 of 1 resident tions.				
	10:30 am with the Admeeting. The Admin performance improve place for developing, policies. She reported to each resident, farmembers to identify neglect. She reported approximately three and the system failed education had not obtain performed Minimum three months. She swere no other MDS esystem failed because MDS coding for a lor Administrator reported place to retain and reyears. She reported spoken to college nun Nursing Assistant (C to recruit new nurses that newly hired staff that was paid out over bonuses, and the fact System' which allowed have a 'confidant' the experiences with. The referral bonuses and both new and season Administrator reported place and monitored	ement plan (PIP) was in /implementing abuse/neglect ed administrative staff talked nily members, and staff any concerns of abuse or				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(С
		345191	B. WING _			03/	27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH CEN	NTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	monitored the medical sign-out sheets for a large reported significant magnitored for twelve was failed because medical monitored long enough facility was doing the Director of Nursing be administrative staff fill absence.	wing narcotics. She ailed because they had not ailed because they had not aition carts and narcotic ang enough period. She edication errors had been weeks however, the system ation errors were not a She explained the best they could due to their being out and other nursing ing in during the DONs & Control		867			4/24/24
SS=K	§483.80 Infection Cor The facility must estal infection prevention a designed to provide a comfortable environm development and trar diseases and infection §483.80(a) Infection program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A systereporting, investigating and communicable distaff, volunteers, visite providing services unarrangement based unification of the stallar o	ntrol blish and maintain an nd control program safe, sanitary and tent and to help prevent the asmission of communicable ans. brevention and control blish an infection prevention IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, brevention and controlling infections seases for all residents, breventing, identifying, g, and controlling infections seases for all residents, breventing, identifying, g, and controlling infections seases for all residents, breventing, identifying, g, and controlling infections seases for all residents, breventing infections seases for all residents, breventing infections seases for all residents, breventing infections					

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		345191	B. WING			1	27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		54	TREET ADDRESS, CITY, STATE, ZIP CODE 42 ALLRED MILL ROAD IOUNT AIRY, NC 27030	1 00	2112427
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	procedures for the probut are not limited to: (i) A system of surveil possible communication infections before they persons in the facility (ii) When and to whore communicable diseast reported; (iii) Standard and transto be followed to prevectiv) When and how is consident; including but (A) The type and durate depending upon the initial involved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances was prohibit employed disease or infected she contact with residents contact will transmit the contact will transmit the least fine of the prohibit employed in the prohibit employed disease or infected she contact will transmit the least fine of the prohibit employed disease or infected she contact will transmit the least fine of the prohibit employed disease or infected she contact will transmit the least fine of the prohibit employed disease or infected she contact will transmit the least fine of the prohibit employed disease or infected she contact will transmit the least fine of the prohibit employed in disease or infected she contact will transmit the least fine of the prohibit employed in disease or infected she contact will transmit the least fine of the prohibit employed in disease or infected she contact will transmit the least fine of the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she contact will be prohibit employed and the prohibit employed in disease or infected she c	standards, policies, and ogram, which must include, blance designed to identify ble diseases or a can spread to other is me possible incidents of se or infections should be assission-based precautions tent spread of infections; blation should be used for a trot limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the se under which the facility the with a communicable is or their food, if direct the disease; and procedures to be followed rect resident contact.	F	880			
	Personnel must hand	le, store, process, and to prevent the spread of riew.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345191	B. WING		C 03/37/3034
NAME OF PE	ROVIDER OR SUPPLIER	0.10.10.1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	03/27/2024
TVAINE OF T	TOVIDER OR GOLT EIER			542 ALLRED MILL ROAD	
SURRY CO	OMMUNITY HEALTH CE	NTER BY HARBORVIEW		MOUNT AIRY, NC 27030	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 880	Continued From page	e 190	F 88	0	
	IPCP and update the This REQUIREMENT by: Based on observation record review, the fact shared blood glucose use and before placing the medication cart. If failed to disinfect a shared blood glucose use and before placing the medication cart. If failed to disinfect a shared blood glucose use and before placing the medication cart. If failed to disinfect a shared glucose update the property of the	act an annual review of its ir program, as necessary. is not met as evidenced is not met as evidenced is staff interviews, and cility staff failed to disinfect a meter (glucometer) after not the glucometer back in furthermore, the facility nared glucometer between		Immediate action(s) taken for the resident(s) found to have been affect include: Nurse #1 on 3/18/24 at approximates approxima	mately I to
	residents with an approut of 4 residents who were checked (Resident Resident #47). This resident with known to facility. Three different deficient practice (Not and Nurse #7). Share contaminated with bleand disinfected after product and procedur Environmental Protect disinfectant in accord manufacturer's instruglucometer has the horesidents to bloodbor	proved disinfectant wipe for 3 cose blood glucose levels ent #60, Resident #54, and occurred while there was a bloodborne pathogens in the first staff were involved in the gree #1, Medication Aide #4 and glucometers can be food and must be cleaned each use with an approved re. Failure to use an cition Agency (EPA)-approved ance with the ctions for disinfection of the ligh likelihood to expose		the top drawer of the cart, properly disinfected the glucometer prior to u again and immediately disinfected the drawer of the cart preventing any chof cross contamination. The DON, of 3/18/24 at approximately 9:00 pm m sure that each cart has the Medline Micro-Kill Bleach Germicidal Wipes use during the disinfecting of the glucometers. This Wipe is listed as approved disinfectant in the Glucom user manual. On 3/18/24 at 9:00 pm DON looked at every chart to see which fingerstick blood sugar (FSBS) test as one resident who had orders for a F-had hepatitis but the resident is on hithat was not affected by the deficien practice so there was no chance of the deficient of the same and the s	sing it ne top ance on ade for an eter n the no got and SBS all 1
	different staff failed to between residents. In removed on 3/20/24 and implemented an allegation of Immedia facility will remain out scope and severity le with a potential for m	o disinfect equipment shared namediate jeopardy was when the facility provided acceptable credible ate Jeopardy removal. The tof compliance at a lower vel of "E" (no actual harm inimal harm that is not to ensure monitoring of ace and to complete		contamination of bloodborne pathog There were no residents in the facilit a diagnosis of Human Immunodefici Virus (HIV) that required a fingerstic blood glucose. 2. Identification of other residents the potential to be affected was accomplished by: " The facility has determined that residents receiving fingerstick blood	ens. by with ency k having

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C 3/ 27/2024	
NAME OF PE	ROVIDER OR SUPPLIER	0.0.0.	 	STREET ADDRESS, CITY, STATE, ZIP CODE		3/2//2024	
TVAINE OF T	TO VIDER OR GOLT EIER				-		
SURRY CO	MMUNITY HEALTH CE	NTER BY HARBORVIEW		542 ALLRED MILL ROAD			
				MOUNT AIRY, NC 27030			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 191	F 88	30			
	The findings included			checks have the potential to b 3. Actions taken/systems pu to reduce the risk of future occ	t into place		
		y's policy entitled "Obtaining		include:			
	•	e [Sugar] Level" (Revised		" Current medication aides	and		
	October 2011) includ	ed:		licensed nurses received train	ing on the		
				Cleaning and Disinfection of			
		ct reusable equipment		Resident-Care Equipment and			
		ling to the manufacturer's		Prevention and Control Progra			
	instructions and curre			Inservice began on 3/18/24.			
	standards of practice	·."		serviced was the importance of	•		
				and disinfecting the glucometer	•		
		y's policy entitled "Cleaning		manufacture 's guidelines usi			
		esident-Care Equipment"		Glucose Monitoring/Cleaning			
	(Dated 3/1/23) includ	ea:		This checklist indicates the fac	-		
				the Medline Micro-Kill germicio			
		sible for routine cleaning and		wipes (or other approved gern			
		esident items after each		wipes) and the contact time re	•		
	use."			minutes. Education ensures the			
	UNA. Itimle necident			understand they have to clean			
	and disinfected after	e equipment shall be cleaned		disinfect them after every use to the manufacturer 's instruc	-		
	and disinfected after	each use.		I			
	"\arify the disinfector	at is sampatible with the		education includes the purpos			
	equipment."	nt is compatible with the		following cleaning check list programmed for the likelihood state of the likel			
	equipinent.			contamination and the spread			
	"Follow manufactures	r recommendations for		borne pathogens among resid			
	cleaning equipment."			education was started on 3/18			
	olcariing equipment.			Director of Nursing, Assistant			
	A review of the facility	y's policy entitled "Infection		Nursing and/or Unit Manager.	Director or		
		rol Program" (Dated 5/23/23;		" All Nurses and Medication	ns Aides		
	reviewed/revised 3/12			(MAs) will be reeducated start			
				by DON, ADON, Unit Manage			
	Equipment Protocol:			Clinical, Administrator and/or I			
	1			Nurse on the Cleaning and Dis			
	"All reusable items ar	nd equipment requiring		Resident-Care Equipment and			
		nfection or sterilization shall		Prevention and Control Progra			
		ance with our current		serviced was the importance of			
		the cleaning and sterilization		and disinfecting the glucometer			

SASSIBLE SAME STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW DISTRICT MOUNT AIRY, LOCAD			345191	B. WING				-	
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW PART SUMMARY STATEMENT OF DEFICIENCIES PART PAR	NAME OF P	ROVIDER OR SLIPPLIER			S	TREET ADDRESS CITY STATE ZIP CODE	03/	2112024	
CALL DATE	TO WILL OF TH	NOVIDER OR COLL FIELD							
F 880 Continued From page 192 f acli later final demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by out facility." The manufacture's User Guide for the glucometer use on each patient." All parts of the glucose monitoring system and out of procedures for the Meter' read in part, The Brand Name] patient on and disinfected between each patient." A list of products approved for cleaning and disinfecting the glucometer use and potentially in the glucometer served for cleaning and disinfecting the glucometer on each patient." A list of products approved for cleaning and disinfecting the manufacturer. The glucometer's manufacturer also noted, "Other EPA registered wipes may be used for disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer also noted, "Other EPA registered wipes may be used for disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer also noted, "Other EPA registered wipes may be used for disinfecting the glucometer was provided by the manufacturer by the performance of your meter. PREFIX TAG CALL COMMENT TAG PROPRIATE COMMENT COMME	SURRY C	OMMUNITY HEALTH C	ENTER BY HARBORVIEW						
F 880 Continued From page 192 of soiled or contaminated equipment." Staff Education: "All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function." "All staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by out facility." The manufacturer's User Guide for the glucometer used at the facility included "Important Safety Instructions." These instructions noted, in part, "All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and precautions and the manufacturer's disinfected or testing multiple patients when standard precautions and the manufacturer's disinfected products approved for cleaning and disinfected between each patient." A list of products approved for cleaning and disinfecting the glucometer's manufacturer also noted, "Other EPA registered wipes may be used for disinfecting the glucometer's manufacturer also noted," Other EPA registered wipes may be used for disinfecting the glucometer of your meter of vour meter of 4/23/2024 for training available and could affect the performance of your meter of the contents of the procedures are followed." The "Cleaning and disinfecting and could affect the performance of your meter of the contents of the procedures of the procedures for the querometer was provided by the manufacturer. The glucometer's manufacturer also noted, "Other EPA registered wipes may be used for disinfecting the glucometer of your meter of the procedure of your meter of your					IV	 T		I	
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"All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention and control program, including policies and procedures related to their job function." "All staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by out facility." The manufacturer's User Guide for the glucometer used at the facility included "Important Safety Instructions." These instructions noted, in part, "All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting blood-borne pathogens between patients and healthcare professionals. The meter should be disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed." The "Cleaning and Disinfecting Procedures for the Meter" read in part, "The [Brand Name] meter should be cleaned and disinfected between each patient." A list of products approved for cleaning and disinfecting the glucometer was provided by the manufacturer. The glucometer's manufacturer also noted, "Other EPA registered wipes may be used for disinfecting the glicuometer's manufacturer also noted," Other EPA registered wipes may be used for teshing and could affect the performance of your meter									
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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	
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NAME OF D	20/4050 00 011001150	343131	D. WING_		ATREET ADDRESS SITV STATE 7/D SODE	03/	27/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SURRY CO	OMMUNITY HEALTH CEI	NTER BY HARBORVIEW	542 ALLRED MILL ROAD		42 ALLRED MILL ROAD		
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F 880	Continued From page	e 193	F 8	880			
F 880	Two types of disinfect at the facility to disinfect at the facility to disinfect were observed on 3/1 medication carts. On name] Disinfect wipe hall medication cart. (Ibrand name] Disinfect the B hall medication PM and 6:17 PM [brawas observed on the 3/18/24 at 4:23 PM [brawas obser	tant wipes available for use ect a shared glucometer 18/24 on the facility's 3/18/24 at 4:30 PM [brand #2 was observed on the D On 3/18/24 at 4:50 PM et wipe #2 was observed on cart. On 3/18/24 at 12:15 and name] Disinfect wipe #1 C hall medication cart. On orand name] Disinfect wipe the A hall medication cart. was a [brand name] bleach d as an approved product by the glucometer for the facility's [Brand Name] ant Wipe #2 was a [brand sinfectant wipe not approved by the glucometers. Disinfectant el did not list the product as an immunodeficiency virus rus (HBV) and hepatitis C duct label indicated the against: "Human a Virus; Staphylococcus soli 0157:H7; taphylococcus aureus; Streptococcus pyogenes; ae; pet dander, dust mite es, grass; Pseudomonas lla enterica; Staphylococcus us; Kills SARS CoV-2 on ices." The product indicated dorize hard, nonporous soiled surfaces, clean first.	F	880	the audits will be corrected immediately and education and/or corrective action done by the DON as appropriate. "The Audit findings will be reported the DON in a Monthly QAPI meeting for minimum of 3 months. 5. The Administrator is responsible for execution of this plan with a compliance date of 4/24/2024.	by ora	
	aureus; Escherichia of Methicillin-resistant S Salmonella enterica; Klebsiella Pneumonia matter, pollen particle aeruginosa; Salmone aureus; Influenza Viruhard nonporous surfa "To Disinfect and deo surfaces: For visibly s Wipe surface; use en	coli 0157:H7; taphylococcus aureus; Streptococcus pyogenes; ae; pet dander, dust mite es, grass; Pseudomonas lla enterica; Staphylococcus us; Kills SARS CoV-2 on ices." The product indicated dorize hard, nonporous					

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F 880	Continued From page	e 194	F 8	880			
	on the product label f decontamination aga indicated.	inst HIV-1, HBV and HCV					
	12:09 PM as Nurse # of test strips, a lancet obtained a glucomete preparation to conduct	s conducted on 3/18/24 at 1 collected supplies (a vial 1, and an alcohol wipe) and 2 from the medication cart in 2 to a blood glucose check for 2 lucometer was not labeled					
	supplies down to Res entering the room, the and supplies down or	carried the glucometer and ident #60's room. After a nurse put the glucometer the resident's bedside tray					
	resident's finger with lancet to obtain a dro and applied the blood the glucometer. Once	gloves, the nurse wiped the an alcohol pad, used a p of blood from his finger I to the test strip inserted into e the blood glucose results					
	lancet, then returned the glucometer. The place the glucometer the medication cart a	#1 discarded the trash and to the medication cart with nurse was observed to back into the top drawer of nd locked the cart. The					
	to whether she had comblood glucose checks nurse stated Residen blood glucose check questioned why she coglucometer after check glucose before placing the top drawer of the						

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 3/27/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•	13/2//2024	
				542 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CE	ENTER BY HARBORVIEW		MOUNT AIRY, NC 27030			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	stated she had been the glucometer befo back into the medica interview, Nurse #1 cart to disinfect the s	gle 195 glucose check. Nurse #1 nervous and forgot to clean re placing the glucometer ation cart. At the end of the returned to the medication shared glucometer and t the glucometer had been	F 8	80			
	placed in using Disir A follow up interview performed on 3/18/2 stated she had 8 res who received blood said she had receive orientation through a computer on bloodb video talked about c and said to use bleat shared glucometers from other places sh wipes were suppose to disinfect. Nurse # (Disinfectant wipe # building. She stated bleach wipes, she w Nurse #1 opened the medication cart and bleach wipes (disinfe in the drawer.	nfectant wipe #1.					
	on 3/18/24 at 4:30 P assigned to D hall. N performing a blood of #47. She verbalized the glucometer and resealable package (disinfectant wipe #2	M of Nurse #7, who was Jurse #7 was observed Jucose check for Resident that she had already cleaned obtained a peel-back of disinfectant wipes 2) from her medication cart to used to clean the glucometer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) ML IDENTIFICATION NUMBER: A. BUIL			CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		,	2	
		345191	B. WING				27/2024	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2112024	
					42 ALLRED MILL ROAD			
SURRY CO	OMMUNITY HEALTH CI	ENTER BY HARBORVIEW			MOUNT AIRY, NC 27030			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 880	Continued From pag	ge 196	F	880				
	with. While Nurse #							
	Assistant Director of							
		#7's medication cart with a						
		ectant Wipe #2 and stated to						
		to make sure you had						
	disinfectant wipes o	n your cart to clean your						
	glucometer." Nurse	#7 held up and showed the						
	•	k resealable package of						
	. ,	disinfectant wipe #2) she had						
		art. The ADON handed Nurse						
		f disinfectant wipes, which						
		ant wipe #2 and stated, "Use						
		r." The ADON then walked						
	•	cation cart. Nurse #7						
		a vial of test strips, a lancet,						
) and obtained a glucometer cart in preparation to conduct						
		ck for Resident #47. The						
	_	labeled with a resident's						
	_	s accompanied as she carried						
		supplies into Resident #47's						
	_	g the room, the nurse put the						
	_	plies down on the resident's						
		While wearing gloves, the						
		ident's finger with an alcohol						
	pad, used a lancet t	o obtain a drop of blood from						
		ed the blood to the test strip						
	inserted into the glu	cometer. Once the blood						
	_	e obtained, Nurse #7						
		and lancet, then returned to						
		with the glucometer. Nurse #7						
	_	ne] Disinfectant wipe #2 from						
	•	lable package of wipes on her						
		lean/ disinfect the glucometer.						
		ved to wrap the disinfectant						
		cometer and placed the						
	_	p drawer of her medication						
		ct Nurse #7 had available on						

l ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345191	B. WING		C 03/27/2024
	ROVIDER OR SUPPLIER DMMUNITY HEALTH C	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	,
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 880	verbalized Residen glucose check on E A follow up interview 5:52 PM with Nurse worked at the facilitishe thought she had clean/ disinfect glucworking at the facilitime ago and did no stated she was not training or check of care, or use of the everbalized any disinfecting the disinfectant said verbalized she had the facility there was that needed to be used to	Disinfectant wipe #2. She t #47 was the last blood t Hall. W was performed on 3/18/24 at t #7. She stated she had ty for 15 months. She recalled d been trained on how to cometers when she started ty, but stated it was a long of recall exactly. Nurse #7 aware of having any yearly f on cleaning/ disinfecting, shared glucometer. She affectant was okay to use for the tit killed germs. Nurse #7 never been told by anyone at ts a specific disinfectant wipe sed for cleaning/ disinfecting eter. She stated she was leaning/ disinfecting products the glucometer from the the glucometer f	F 880		
	alcohol wipe) and of medication cart in publicose check for F was not labeled with was accompanied and supplies into R	est strips, a lancet, and an btained a glucometer from the reparation to conduct a blood desident #54. The glucometer in a resident's name. MA #4 as she carried the glucometer desident #54's room. After the nurse put the glucometer			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 3/27/2024	
	ROVIDER OR SUPPLIER	CENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CO 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	•	S12112024	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	table. While wear resident's finger was lancet to obtain a and applied the bit the glucometer. Owere obtained, Malancet, then return the glucometer. Moisinfectant wipes clean/disinfectant wipes clean/disinfectant wipes clean/disinfectant wipes wipe around the glucometer wrapp clean plastic cup ocart. MA #4 explain glucometer wrapp 5 minutes. MA #4 know 4-5 minutes glucometer until a hall came and told stated there were cart and she woul "wrapped" in the oproduct MA #4 had disinfect the share name] Disinfectant had 2 residents letesting for but the hall visiting with far An interview was a to disinfect the share and told stated there was a to disinfect the share and the shall visiting with far and shall can be the shall visiting with far and controlled the shall visiting with shall visiting with far and controlled the shall visiting with shall visiting with shall visiting w	in on the resident's bedside tray ing gloves, the nurse wiped the rith an alcohol pad, used a drop of blood from his finger ood to the test strip inserted into once the blood glucose results A #4 discarded the trash and red to the medication cart with IA #4 retrieved [brand name] #2 from a pop-up container of on her medication cart to be glucometer. MA #4 was off the glucometer using #2 then, wrap the disinfectant llucometer. She then placed the red in the disinfectant wipe in a son the top of the medication ned she would leave the red in the disinfectant wipe for 4-further explained she did not was needed to disinfect the Nurse working on a different I her a little while ago. She 2 shared glucometers on her d use one while the other was disinfectant wipe. The only d available on her cart to clean/ and glucometer was [brand the wipe #2. MA #4 stated she fit to perform blood glucose residents were currently off the	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING			C 03/27/2024	
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIF 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		3312112024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 880	glucometer from the MA #4 stated no one her what type of wipe glucometer. She verb which wipe to use un she used to see Disir had stopped seeing to maybe Disinfectant with 4 said the Unit Manaher on 3/18/24 and slate to use to clean/disinfectant with stated 9 resident blood glucose checks. An attempt was made was not available. An interview was performed, and the Supporder. He stated he do Disinfectant wipe #2 explained housekeep cleaner that was disposed formed with the Sonly ordered [brand or He explained he did or Disinfectant wipe #2. Disinfectant wipe #3. An interview was perfordered the supplies.	es for cleaning the shared Housekeeping Supervisor. at the facility had ever told to use to clean the shared balized she did not know till today. MA #4 explained affectant wipe #1 but that she hem. She stated she thought wipe #1 went out of stock. MA ager (UM) had spoken with howed her the proper wipes ect the shared glucometer. Its on B hall had received as today. The formed on 3/22/24 at 9:41 seping Supervisor. He stated ply Manager what he ply Manager would place the bid not have [brand name] in housekeeping. He bing used one product of sensed through a machine. AM an interview was supply Manager. He stated he hame] Disinfectant wipe #1. Into order the [brand name] was not on the facility's not know where staff had om. He verbalized he also	F	380			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP CODE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	'	00/21/2024
(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 CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	and Staff Developm ADON stated she was needed to be clean residents. She state "Clorox" wipes ([bra#2) to clean the shatold staff to use "Cleexplained she calle "Clorox" wipes and difference in the difficated she told the stated she told s	Infection Preventionist (IP) Infection Prevention Preventionist (IP) Infection Prevention Prev	F			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345191	B. WING _				27/ 2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		5	STREET ADDRESS, CITY, STATE, ZIP CODE 642 ALLRED MILL ROAD MOUNT AIRY, NC 27030	1 001	2172027
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880		using the disinfectant wipes	F	880			
	that were approved b manufacturer for disir	nfecting.					
	PM with the Administr						
	manufacturer instruct disinfecting a glucomo staff should follow pol	oions and a nurse not eter after use. They stated icy for shared glucometers.					
	They said the policy stated, to clean/disinfect glucometers between patient use. They said disinfection and cleaning time should be done per manufacturer guidelines. The Administrator						
	stated glucometer dis performed to prevent bloodborne pathogen she could not speak t	the transmission of s. The Administrator stated					
	Disinfectant wipe #2 v shared glucometers.	was used for disinfecting The Administrator said ctant wipe #2 were not					
	facility, and were not The Administrator exp	lity, not obtained by the on the facility's formulary.					
	for disinfecting glucor education on the gluc	ng sure what product to use neters and staff needed ometer manufacturer the correct disinfectant per					
	manufacturer guidelir stated Nurse #1 did n after use because sho	nes. The Administrator of disinfect the glucometer was nervous and was ure the medication cart was					
	and medical diagnose	onic medical record (EMR) es for current residents at cted. One resident was					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	1	(X3) DATE SURVEY COMPLETED
		345191	B. WING _			C 03/27/2024
	ROVIDER OR SUPPLIER	NTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIAT ICIENCY)	DATE
F 880	Continued From pag	e 202	F 8	380		
		liagnoses which included a n (Chronic Hepatitis C				
	· •	trator and DON were ediate jeopardy on 3/18/24 at				
		l an acceptable credible ate jeopardy removal.				
	The following interve remove the immediate	ntions were put into place to te jeopardy:				
	are likely to suffer, a	oients who have suffered, or serious adverse outcome as mpliance. (Completion date				
	disinfect shared gluc failed to disinfect gluc Nursing staff on halls using disinfectant wip recommended in the guidelines. Nurse #1 12:15 pm after return removed the glucome the cart, properly disi to using it again and top drawer of the car cross contamination. approximately 9:00 phas the Medline Micr Wipes for use during glucometers. This w disinfectant in the Gli	infecting wipes to clean and ometers by nurse #1 who cometer after use and 2 and 4 were observed				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	· ,	(X3) DATE SURVEY COMPLETED	
		345191	B. WING _			C 03/27/2024	
	ROVIDER OR SUPPLIER	ENTER BY HARBORVIEW		STREET ADDRESS, CITY, STATE, ZIP COD 542 ALLRED MILL ROAD MOUNT AIRY, NC 27030		00/21/2024	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 880	test and one reside had hepatitis, but the was not affected by was no chance of colloodborne pathogo in the facility with a Immunodeficiency of fingerstick blood global street in the facility with a Immunodeficiency of fingerstick blood global street in the facility of the action process or system adverse outcome frowhen the action will (Completion date 3). The facility's policies and Disinfection of reviewed on 3/18/2 the DON, Administrate Regional Nurse Colonand VP of Clinical. The participants on of Resident-Care Enevention and Comportance of proportions contamination. Current medication receive training on of Resident-Care Enevention and Colonand C	erstick blood sugar (FSBS) and who had orders for a FSBS are resident is on hall 1 that the deficient practice so there ross contamination of ens. There were no residents diagnosis of Human Virus (HIV) that required acose. In the entity will take to alter the failure to prevent a serious om occurring or recurring, and I be complete. (20/24) Is and procedures on Cleaning Resident-Care Equipment was A at approximately 6:30 pm by rator, ADON/IP, Unit Manager, insultant, Regional Operations, The VP of Clinical in-serviced the Cleaning and Disinfection quipment policy, Infection introl Program policy and the er disinfection to prevent the in of Bloodborne Pathogens. aides and licensed nurses will the Cleaning and Disinfection quipment and Infection introl Program. Inservice t approximately 7:00 pm. as the importance of cleaning	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				_		1 (c	
		345191	B. WING			1	27/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/		
				5	42 ALLRED MILL ROAD			
SURRY C	OMMUNITY HEALTH C	CENTER BY HARBORVIEW			MOUNT AIRY, NC 27030			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 880	Continued From page 204		F	880				
	Micro-Kill germicidal bleach wipes and the							
		ed is 5 minutes. Education						
	ensures that staff u							
	and disinfect them							
	the manufacturer '							
	includes the purpos							
	list process for glud							
	of cross contamina							
	bloodborne pathogens among residents. This							
	education was started on 3/18/24 at							
	approximately 7:00 pm by the Director of Nursing,							
	Assistant Director of Nursing and/or Unit							
	Manager. Effective							
	licensed nurse will do a fingerstick blood sugar							
	check without the v							
	monitoring checklis							
	and new staff. The							
	responsible for kee							
	completion of the b							
	checklist. The Med							
	the Director of Nurs							
	Immediate Jeopard							
	glucometers and th							
	procedures require	d per manufacturer's						
	guidelines were no							
	Directors only recommendation was to follow							
	manufactures guidelines for the glucometer							
	disinfection. On 3/19/24 the DON, ADON/IC							
	and/or Unit Manager notified all the residents that							
	had Accuchecks on hall 2 and 4 with BIMS above							
	8 and/or their responsible parties to notify them of							
	potential for bloodborne pathogen exposure. All							
	voiced understanding and denied having any							
	concerns. The DC							
	l '	9/24 at approximately 9:00 am.						
	The Local Health D							
	would have to call t							
	would let us know i	•						
	recommendations.	The facility alleges removal of						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345191	B. WING _			l	27/ 2024	
NAME OF PI	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112024	
SURRY COMMUNITY HEALTH CENTER BY HARBORVIEW				542 ALLRED MILL ROAD				
				MOUNT AIRY, NC 27030				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)			(X5) COMPLETION DATE	
F 880	Continued From page 205		F 8	380				
	immediate jeopardy on 3/20/24.							
	The immediate jeopa 3/20/24.	rdy was removed on						
	On 3/22/24 the facility immediate jeopardy refollowing:							
	administrative interviet the required infection glucometers. Observative revealed the facility hassigned glucometers blood glucose monitor glucometers were lab stored in individually education included recontrol policy and marelated to glucometers.	ations were conducted and ad implemented individually some for each resident requiring						