PRINTED: 07/09/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345356	B. WING _			06/0) 06/2024	
	ROVIDER OR SUPPLIER JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		1 00/0	7072024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
E 000	Initial Comments An unannounced rec	ertification and complaint	E 0	00				
F 000	investigation survey was through 6/6/24. The compliance with the r	vas conducted on 6/3/24 facility was found in requirement CFR 483.73, rness. Event ID #21MQ11.	F 0	00				
F 623	A recertification and complaint investigation survey was conducted from 6/3/24 through 6/6/24. Event ID# 21MQ11 The following intake was investigated: NC00215991. 3 of the 3 complaint allegations did not result in deficiency. Notice Requirements Before Transfer/Discharge		F 6	23			7/1/24	
SS=B	S483.15(c)(3) Notice Before a facility trans resident, the facility in (i) Notify the resident representative(s) of the reasons for the manguage and mannefacility must send a crepresentative of the Long-Term Care Ombedii) Record the reason discharge in the residuaccordance with para and (iii) Include in the notiparagraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specified (c)(8) of this section,	before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State oudsman. ns for the transfer or lent's medical record in agraph (c)(2) of this section; ice the items described in is section.						
ABORATORY I		SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		((X6) DATE	

Electronically Signed 06/28/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345356	B. WING				06/ 2024	
	ROVIDER OR SUPPLIER JARE NURSING & REHA	AB		3	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH MAIN STREET RICH SQUARE, NC 27869			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 623	resident is transferred (ii) Notice must be made before transfer or dis (A) The safety of individe endangered under this section; (B) The health of individe endangered, under this section; (C) The resident's heallow a more immediate under paragraph (c)((D) An immediate transferred by the reside under paragraph (c)((E) A resident has not days. §483.15(c)(5) Conternotice specified in paramust include the follow (i) The reason for transferred or dischard (iii) The location to with transferred or dischard (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Oml	It least 30 days before the dor discharged. It least 30 days before the dor discharged. It ade as soon as practicable charge when- viduals in the facility would a paragraph (c)(1)(i)(C) of viduals in the facility would be paragraph (c)(1)(i)(D) of alth improves sufficiently to atte transfer or discharge, 1)(i)(B) of this section; ansfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or to resided in the facility for 30 and the facility for 30 and the resident is reged; and the resident is reged; are resident's appeal rights, address (mailing and email), and the office of the State budsman; by residents with intellectual	F	623				

OATE SURVEY OMPLETED		E CONSTRUCTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN				
C 06/06/2024				B. WING _	345356		
30,730,720,7	<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 800 NORTH MAIN STREET RICH SQUARE, NC 27869	300 NOR		AB	ROVIDER OR SUPPLIER UARE NURSING & REHA	
(X5) COMPLETION DATE	OULD BE	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		ID PREFIX TAG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	(EACH DEFICIENC)	(X4) ID PREFIX TAG
		F Tag 623 Notice Requirements Befo	F Ta Tran	F 6	the agency responsible for agency of individuals with a dilities established under Part atal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder a Protection and Advocacy duals Act. The notice changes prior to or discharge, the facility poients of the notice as soon the updated information In advance of facility closure closure, the individual who is the facility must provide for to the impending closure agency, the Office of the the Ombudsman, residents of the esident representatives, as the transfer and adequate dents, as required at § This not met as evidenced are individual to provide accility failed to provide	telephone number of the protection and addevelopmental disabil C of the Development and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related disemail address and tel agency responsible for advocacy of individual established under the for Mentally III Individual established under the effecting the transfer of the under the information in the effecting the transfer of the ecomes available. §483.15(c)(8) Notice is in the case of facility of the administrator of the written notification print to the State Survey Agental State Long-Term Care the facility, and the rewell as the plan for the relocation of the residual 483.70(I). This REQUIREMENT by: Based on record revistaff interviews, the facility and the facility and the residual experience of the residual e	F 623
)		Tran A. acco		ty residents with a mental sabilities, the mailing and lephone number of the or the protection and als with a mental disorder e Protection and Advocacy fuals Act. The est to the notice. The notice changes prior to or discharge, the facility poients of the notice as soon the updated information The facility must provide for to the impending closure agency, the Office of the the Ombudsman, residents of the estate transfer and adequate dents, as required at § This not met as evidenced free in the provide agency and the provide agency are transfer and adequate dents, as required at § This not met as evidenced free, where the provide agency are transfer and adequate dents, as required at §	(vii) For nursing facilit disorder or related disemail address and tel agency responsible for advocacy of individual established under the for Mentally III Individual stablished under the for Mentally III Individual stablished under the for Mentally III Individual stable. See Section 15 (c) (6) Change If the information in the effecting the transfer of must update the recip as practicable once the becomes available. See Section 15 (c) (8) Notice in the case of facility of the administrator of the written notification print to the State Survey Astate Long-Term Care the facility, and the rewell as the plan for the relocation of the residual stable. This REQUIREMENT by: Based on record revistaff interviews, the facility notice of transland to the ombudsmannian stable st	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345356	B. WING _				C / 06/2024	
	ROVIDER OR SUPPLIER JARE NURSING & REHA	λB	•	30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 NORTH MAIN STREET ICH SQUARE, NC 27869	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page	e 3	F 6	523				
		for hospitalization (Resident			Resident #29 was admitted bac the facility and still resides here. B. How corrective action will be	k to		
	Findings included:				accomplished for resident(s) having potential to be affected by same issue			
	09/29/2020. Residenthe facility and admitted	mitted to the facility on t #29 was discharged from ed to the hospital on t #29 returned to the facility			needing to be addressed: On June 20, 2024, the DON reviewed residents with immediate discharge/ transfer to hospi in last 7 days who had not received the written notification for reason of discharge.	n tal e		
	record (EMR) revealed	#29's electronic medical ed no written notice of Resident #29 related to the 14/2023.			to the hospital. No residents were identified. C. What measure will be put in place or systemic changes made to ensure the identified issue does not occur in the future? To prevent this from happening	hat ne		
	The quarterly Minimu assessment dated 5/ #29 was cognitively in	21/2024 indicated Resident			again on June 21, 2024 the Administra and Director of Nursing provided education to licensed nurses, social worker and business office manager o	tor		
	Resident #29, she sta written letter notifying	a.m. in an interview with ated she had not received a her of the reason she was facility to the hospital on			the discharge/ transfer letter policy. D. Indicate how facility plans to moi its performance to make sure that solu is achieved and sustained: Nursing Ho Administrator/ Designee will audit residents discharged to the hospital 5	tion		
	Clinical Nurse Consu unable to locate a wr transfer/discharge for related to Resident # to the hospital on 12/ February 2024 she ic	Resident #29 in the EMR 29's transfer from the facility 14/2023. She explained in lentified the facility was not			times per week for 12 weeks to ensure residents discharged to the hospital received written notification of reason transfer to the hospital. Business office manager/ Social worker will send a color of the state specific discharge letter to resident/ resident's responsible party a	or S		
	the resident or reside residents were transf facility.	ce of transfer/discharge to int representatives when erred/discharged from the			soon as practicable. The business office manager /social Worker will send a color via email to ombudsman monthly. NH designee will bring the results of the audits to the monthly Quality Assurance and the sentence of the se	oy A/ e		
	On 6/6/2024 at 10:00	a.m. in an interview with the			performance Indicator meeting for revi	₩		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C / 06/2024
	ROVIDER OR SUPPLIER	АВ		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	1 00/	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	in long term care price began employment of December 2023 she ombudsman of reside discharges from the was not notified of Retransfer/discharge of she started sending for 30-day discharge ombudsman of all redischarges in Februar required notification. On 6/6/2024 at 10:20 Director of Nursing (11/29/2023), she stafacility had not provice representatives a writer transfer/discharge at why the facility had residents transferred at written notice of transfersidents transferred facility, the nursing sprocess. On 6/6/2024 at 10:10 Administrator, he safombudsman did not the reason of Reside on 12/14/2023 because ident representation.	explained she had not worked or to July 2023 when she with the facility. She stated in had not notified the ents' transfers and facility, and the ombudsman esident #29's in 12/14/2023. She explained monthly notifications, except in notifications, to the sident transfers and any 2024 upon learning of the process. 3 a.m. in an interview with the who started at the facility on ted in December 2023 the ded residents or resident itten notice of and was not able to explain not provided the notification. Ilearning in February 2024 in provide residents or resident the ombudsman with a sfer/discharge when a or discharged from the taff were educated on the continuous and the receive written notification for ent #29's transfer/discharge use an issue with residents or twes and the ombudsman not notice of transfer/discharge	F 62	for 3 months, or longer as deemed necessary by the QAPI committee. Revisions will be made as needed.		
F 625 SS=B		Policy Before/Upon Trnsfr	F 62	5		7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345356	B. WING _			C 06/06/2024	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	00/00/2024	
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F 625	§483.15(d)(1) Notice nursing facility transfithe resident goes on nursing facility must put the resident or resident specifies- (i) The duration of the any, during which the return and resume refacility; (ii) The reserve bed pulan, under § 447.40 (iii) The nursing facility bed-hold periods, who		Fé	325			
	of this section. §483.15(d)(2) Bed-hot the time of transfer or hospitalization or the facility must provide to resident representation specifies the duration described in paragra. This REQUIREMENT by: Based on record revistaff interviews, the fibed hold policy in writh 1 of 2 residents reviews.	pecified in paragraph (e)(1) old notice upon transfer. At if a resident for rapeutic leave, a nursing to the resident and the we written notice which if of the bed-hold policy oh (d)(1) of this section. If is not met as evidenced iew, resident interview and acility failed to provide the ting at the time of transfer to wed for discharged to the 19. This practice had the		F625 Notice of Bed Hold Police Upon Transfer A. How corrective action will accomplished for residents(s) have been affected: Resident readmitted to facility and curreresides in the facility.	l be found to #29 was		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345356	B. WING _			06	/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				30	00 NORTH MAIN STREET			
RICH SQ	JARE NURSING & REH	AB		R	ICH SQUARE, NC 27869			
(X4) ID		TATEMENT 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 625	Continued From pag	ge 6	F 6	325				
	Findings included:	•			B. How corrective action will be			
	i mango moladoa.				accomplished for resident(s) having			
	Resident #29 was a	dmitted to the facility on			potential to be affected by same issue			
		nt #29 was discharged from			needing to be addressed: The facility			
	the facility and admi	tted to the hospital on			Director of Nursing on June 20, 2024,			
	12/14/2023.				reviewed residents with immediate			
					discharge/ transfer to hospital in the la	st 7		
		tion on 12/14/2023 at 4:28			days to identify anyone affected by this	3		
		lent #29 requested to go to			issue. No residents were identified as			
		eeling weak. The physician			affected by this deficient practice.			
		Representative were notified,			C. What measure will be put in place			
		as sent to the hospital for an			or systemic changes made to ensure t			
	evaluation.				the identified issue does not occur in the			
		on a material in Desident #2015			future? To prevent this from happening			
		nentation in Resident #29's			again, the licensed nurses, social work	er		
	policy was provided	ecord (EMR) that the bed hold			and business office manager were educated on the bed hold policy by the			
		ne was transferred and			Administrator and Director of Nursing			
	admitted to the hosp				June 21, 2024.	J11		
	admitted to the hoof	nai.			D. Indicate how facility plans to mor	itor		
	Resident #29 return	ed to the facility on			its performance to make sure that solu			
	12/17/2023.	- u			is achieved and sustained: Nursing Ho			
					Administrator/ designee will audit			
	The quarterly Minim	um Data Set (MDS)			immediate discharges 5 times per wee	k		
	assessment dated 5	/21/2024 indicated Resident			for 12 weeks to ensure residents			
	#29 was cognitively	intact.			discharged to the hospital received the	:		
					bed hold letter. Business office manag	er/		
	On 6/6/2024 at 7:12	a.m. in an interview with			Social Worker will mail a copy the bed			
	[· · · · · · · · · · · · · · · · · · ·	tated she did not recall			hold policy to the resident/ residents			
		policy from the facility on			representative as soon as practicable			
		ne was transferred to the			after resident is discharged to the			
	hospital.				hospital. The LNHA/ designee will brin	-		
	On 6/6/2024 -+ 0:42	a main an interview with the			the results of the audits to be reviewed			
		a.m. in an interview with the			monthly Quality Assurance Performance			
	unable to locate in F	ultant, she stated she was			Indicators meeting for 3 months; or lor	gei		
		dent #29 was issued the bed			as deemed necessary by the QAPI committee.			
		/2023 when transferred from			COMMITTEE.			
		enital. She evolained in						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER JARE NURSING & REH	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	1 33/33/2324	
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
F 625	issuing the bed hold resident representati transferred from the On 6/6/2024 at 10:23 Director of Nursing (11/29/2023), she sta facility was not issuir representatives the but transferred from the not able to explain when the bed hold policy. Sacility was informed to provide residents with the bed hold polithe facility, the nursing transferred from the not able to explain when the bed hold polity.	s identified the facility was not policy to residents or wes when residents were facility. B a.m. in an interview with the who started at the facility on ted in December 2023 the ag residents or resident ped hold policy when facility. She stated she was hy the facility was not issuing She explained when the in February 2024 of the need or resident representatives icy when transferred from ag staff were educated on policy when transferring	F 6.	25		
F 637 SS=D	Administrator, he sai issued the bed hold the facility on 12/14/2 facility was not award residents or resident receiving the bed ho from the facility until Comprehensive Asso CFR(s): 483.20(b)(2) §483.20(b)(2)(ii) With determines, or should there has been a signesident's physical or purpose of this section means a major declining the facility of the said of the sa	d policy when transferring February 2024. essment After Signifcant Chg	F 6	37	7/1/24	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, 50.25			(
		345356	B. WING_			1	06/2024	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DICH SOL	IADE NUDCINO 9 DEUA	В		30	00 NORTH MAIN STREET			
KICH SQL	JARE NURSING & REHA	В		R	ICH SQUARE, NC 27869			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 637	implementing standar interventions, that has one area of the reside requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on staff interv facility failed to perfor Status Minimum Data 1 of 1 resident review (Resident #38). Findings included: Resident #38 was add 7/6/22 with diagnoses and dementia. Review of Resident # revealed she was recto admission to the fareceive services upor Review of a Centers of Services (CMS) Notic Non-Coverage (NOM 12/21/23 revealed Reservices were ending Review of Resident #Data Set (MDS) asserevealed she received the lookback period.	ntervention by staff or by and disease-related clinical as an impact on more than ant's health status, and ary review or revision of the as is not met as evidenced as and record review the as a Significant Change in a Set (MDS) assessment for a for hospice care mitted to the facility on a that included hypertension as's medical records eiving hospice services prior cility and continued to a admission. for Medicare and Medicaid are of Medicare NC, form 10123) dated sident #38's hospice	F	337	F Tag 637 A. Corrective action for resident(s) affected by the alleged deficient practic. The MDS coordinator completed a significant change on 06/06/2024 for resident #38. B. How corrective action will be accomplished for resident(s) having potential to be affected by same issue needing to be addressed: the MDS coordinator completed a 100% audit or residents on 6/10/2024 to assure no ott significant changes noted. No other issues noted. C. What measure will be put in place systemic changes made to ensure that the identified issue does not occur in the future? the Regional Clinical Reimbursement Consultant provided re-education to the Minimum Data Set Coordinator (MDS) on 6/20/2024 regarding the need for a significant change in status in the MDS within 14 days of significant change being identif D. Indicate how the facility plans to monitor its performance to make sure t solution is achieved and sustained: the Regional MDS consultant/designee wi audit 3 residents weekly for 12 weeks f	n her or he		
	services during the lo	okback period.			any condition that requires a significant change assessment. The Licensed	<u> </u>		

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(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 695 SS=D	Review of Resident 3 revealed a significant not been completed wischarged from hosp. During an interview of Coordinator on 6/5/24 during December she the facility and was not significant change as during the transition. An interview was con Administrator on 6/6/6 MDS assessments should require time frames. Coordinator was tran December, and the facility and the facility and the facility fraction oversight. Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and tracheal succare, consistent with practice, the comprehence and 483.65 of this su	ask's MDS assessments a change assessment had when Resident #38 had been bice services. onducted with the MDS at at 2:40 PM she stated a had just begun working in ot aware Resident #38's sessment was not done ducted with the 24 at 11:10 AM who stated hould be done within the and He further stated the MDS sitioning to the facility during allure to complete a sessment when Resident graph hospice services was an astomy Care and Suctioning and tracheal suctioning. The provided such professional standards of the nesive person-centered ants' goals and preferences,	F 6	Nursing Home Administrator/obring results from the audit to to the QAPI meeting for 3 more longer if deemed necessary becommittee.	be review oths or	ved	7/1/24
	Based on record rev interviews, the facility	iew, observations and staff r failed to obtain a physician upplemental oxygen and		F Tag 695 Respiratory/Trache Care and Suctioning A. Corrective action for resi	_		

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII		700/2024	
				300 NORTH MAIN STREET			
RICH SQ	JARE NURSING & REHA	ΛB		RICH SQUARE, NC 27869			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ACTION SHOULD BE TO THE APPROPRIATE	COMPLETION DATE	
F 695	Tarana a managa ma		F 69	95			
		ing the use of oxygen		affected by the alleged d	leficient practice:		
		room for 1 of 3 residents		Physician was notified, a			
	reviewed for oxygen	use (Resident #152).		were immediately obtain			
				#152. Oxygen sign was a	also placed on the		
	The findings included	l:		door.			
	Decident #450			B. How corrective action			
		e-admitted to the facility on		accomplished for resider potential to be affected b	` ,		
		ses including congestive onic respiratory failure.		needing to be addressed	-		
	ricart failure, and criiv	one respiratory failure.		Nursing completed a 100			
	The care plan dated	3/27/24 indicated Resident		June7, 2024 of all reside			
	#152 was using oxyg			oxygen with no other res			
	0 70			C. What measure will			
	Review of the quarter	rly Minimum Data Set (MDS)		systemic changes made	to ensure that		
	assessment dated 4/	18/24 indicated Resident		the identified issue does			
	_	ognitively impaired and the		future? ON June 7,2024			
	use of oxygen.			Nursing educated license			
	Ni maina da arma antati			medication aides on the			
		on dated 5/30/24 recorded urn to the facility 10:25 pm		procedures of oxygen us	se and obtaining		
		ters per minute via nasal		physician orders D. Indicate how facility	v plane to monitor		
	cannula.	ters per minute via nasar		its performance to make			
	odimad.			is achieved and sustaine			
	Further nursing docu	mentation dated 5/31/24 at		Nursing/ unit manager, w			
		esident #152 receiving		orders and admissions 5			
	oxygen via nasal can	nula at 2 liters per minute.		12 weeks to ensure that	residents		
				requiring oxygen have cu			
		ian's order for the use of		place and oxygen sign o			
	oxygen in Resident #	152's medical record.		resident⊡s door. The Lic	•		
	Om 0/4/04 -+ 0:40	41		Home Administrator/desi	-		
		i, there was no signage i2's room indicating the use		results of the audits to be			
		#152 was observed wearing		QAPI meeting for 3 month deemed necessary by the	_		
		nula at 3 liters per minute.		committee.	IE QAFI		
	onygon na nasar can	naia at o moro por minuto.		0011111111100.			
	On 6/5/24 at 3:28 pm	in an interview with Nurse					
		e did not recognize there				 	
		se, no smoking" signage					
	outside his door. She	e stated an "Oxygen in use,					

Facility ID: 923433

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345356	B. WING _			C 06/06/2024	
	ROVIDER OR SUPPLIER JARE NURSING & REHA	AB		STREET ADDRESS, CITY, STATE, ZIF 300 NORTH MAIN STREET RICH SQUARE, NC 27869		00/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	Continued From page 11 no smoking" signage should have been placed		F 6	695			
		2's door when he was sing staff recognized					
	Unit Manager, she ex recognize there was	in an interview with Nurse splained she did not not a "Oxygen in use, no t Resident #152's door. She					
	stated an "Oxygen in should have been pla door when he was ac	use, no smoking" signage ced outside Resident #152's mitted or when nursing staff vas not outside the door.					
	After reviewing Resid Unit Manager stated use of 2 liters per mir	ent#152's orders, Nurse there was no order for the oute of oxygen for Resident					
	nurse could enter a p oxygen and stated sh was not an order in R	's orders. She explained any hysician order for the use of he did not know why there hesident #262's electronic) for the use of oxygen.					
	Director of Nursing, s have called the physi he returned from the use of oxygen. The r	n. in an interview with the he stated nursing should cian for Resident #152 when hospital for an order for the nursing staff should have he use of oxygen into the 52. She indicated the					
	minute of oxygen who but usually called the oxygen was needed. staff was responsible use, no smoking" sign #152's door due to oxygen who was no smoking sign #152's door due to oxygen who was not smoking sign #152's door due to oxygen who was needed.						
F 883 SS=D	Influenza and Pneum CFR(s): 483.80(d)(1)	ococcal Immunizations (2)	F 8	383		7/1/24	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING			C 6/06/2024
NAME OF PROVIDER OR SUPPLIER RICH SQUARE NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC 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 883	policies and procedur (i) Before offering the each resident or the receives education repotential side effects (ii) Each resident is o immunization Octobe annually, unless the icontraindicated or the immunized during this (iii) The resident or that the opportunity to (iv)The resident's me documentation that ir following: (A) That the resident was provided educati and potential side effimmunization; and (B) That the resident immunization or did nimmunization due to refusal. §483.80(d)(2) Pneummust develop policies that- (i) Before offering the immunization, each representative receiv benefits and potential immunization;	za. The facility must develop res to ensure that- influenza immunization, resident's representative regarding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically resident has already been resident has already been retime period; reresident's representative refuse immunization; and dical record includes redical record includes redically resident record includes redically resident record includes redically resident record includes	F 88	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345356	B. WING_		,	C 06/06/2024	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		16/06/2024	
				300 NORTH MAIN STREET			
RICH SQL	JARE NURSING & REHA	AB		RICH SQUARE, NC 27869			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 883	Continued From page	e 13	F 8	83			
F 883	medically contraindical ready been immunically been immunically contrained to the has the opportunity to (iv) The resident's medocumentation that infollowing: (A) That the resident was provided education and potential side efficient immunization; and (B) That the resident pneumococcal immunication or retries and potential side efficient immunization; and (B) That the resident pneumococcal immunication or retries REQUIREMENT by: Based on record revifacility failed to docur the influenza vaccine pneumococcal vaccing resident representativinfluenza vaccine (20 pneumococcal vaccing reviewed for immunical Resident #152). Findings included: 1. a. Resident #41 was 8/02/2023.	ated or the resident has zed; the resident's representative to refuse immunization; and dical record includes adicates, at a minimum, the cor resident's representative on regarding the benefits the ects of pneumococcal either received the mization or did not receive immunization due to medical fusal. To is not met as evidenced item and staff interviews, the ment providing education of (2023-2024 season) and the eand the resident's or ze's refusal to receive the 23-2024 season) and the for 2 of 6 residents reations (Resident #41 and eas admitted to the facility on the east admitted to the facility of the east admitted to the	F 8	F Tag 883 Influenza and Pneu Immunizations A. How corrective action wil accomplished for residents(s) f have been affected: The Direct Nursing offered residents #152 pneumococcal vaccination. Infl vaccination was not offered due outside of flu season dates. On the DON offered and received from Residents representative residents #152 and #41. The D provided education for both Re Representative. On 6/21/2024	I be found to tor of 2 and #41 uenza e to being n 6/20/2024 consent for DON esident		
	The quarterly Minimu assessment dated 3/ #41 was severely imp	7/2024 indicated Resident		administered the Pneumococci immunization to resident #152 Resident #41. B. How corrective action will	and		
		entation in the electronic) Resident #41 had received (2023-2024 season).		accomplished for resident(s) had potential to be affected by sam needing to be addressed: The	aving e issue		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C 6/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	1.000		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	0/00/2024	
				300 NORTH MAIN STREET			
RICH SQ	JARE NURSING & REHA	AB		RICH SQUARE, NC 27869			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 883		nt #41 reported no past	F 88	Nursing/ designee completed 1 of influenza and pneumococca	I		
	vaccine. The facility was unab	41 receiving a pneumococcal		vaccinations on June 21,2024 issues identified were addresse completed by 7/1/2024. C. What measure will be page 1.5.	ed and		
	documentation Resid Representative had r influenza vaccine (20 pneumococcal vaccir administration or refu influenza vaccine (20 pneumococcal vaccir b. Resident #152 was 5/19/2021.	lent #41 or Resident #41's eceived education for the 123-2024 season) and ne to consent for usal of administration of the 123-2024 season) and the ne. s admitted to the facility on #152's electronic medical		or systemic changes made to e the identified issue does not of future? On 06/20/2024, the Dire Nursing and the Nurse Manage were re-educated on The pneu and Influenza immunization po procedures by the Clinical Nurs Consultant. D. Indicate how facility plans its performance to make sure the is achieved and sustained: The Nursing/designee will audit new admissions 5 times a week for	ensure that ccur in the ector of ement team imococcal licy and se s to monitor that solution e Director of v 12 weeks.		
	the influenza and pne The quarterly Minimu	nm Data Set (MDS) 18/2024 indicated Resident npaired cognitively.		To ensure residents were provied education and offered the influeduring flu season) and pneumovaccinations and any declination. The License Nursing Home Administrator/designee will bring the audits to be reviewed in Quassurance performance improv	enza (if ococcal on signed. In gresults of lality		
	Resident #152 had re (2023-2024 season). The EMR for Resider history of Resident # pneumococcal vaccir The facility was unab documentation Resid Representative had re	eceived the influenza vaccine nt #152 reported no past 152 receiving a ne.		meeting for 3 months or longer committee deems necessary.			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345356	B. WING			C 06/2024
NAME OF PR	ROVIDER OR SUPPLIER	V.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	1 06/	00/2024
RICH SQL	JARE NURSING & REHA	В		300 NORTH MAIN STREET RICH SQUARE, NC 27869		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883 F 887 SS=D	influenza vaccine (20 pneumococcal vaccine On 6/6/2024 at 1:01 p Director of Nursing (w Infection Preventionis the facility on 11/30/2 annual influenza vaccio was offered and admi resident representativa at the facility. She sta the pneumococcal varesident representativa obtained a written cor vaccine was to be add #41 and Resident #15 refused the vaccines, documentation. She residents or resident if they wanted to rece (2023-2024 season) a the facility was not ob that stated education vaccines, and the res representative refuse influenza vaccine (20 pneumococcal vaccine COVID-19 Immunizati	sal of administration of the 23-2024 season) and de. o.m. in an interview with the who was also acting as the st), she stated she started at 023. She explained the sine (2023-2024 season) inistered to all residents or wes prior to her employment ted in May 2024 she offered coine to the all residents or wes. She stated the facility insent for a vaccine when a ministered and if Resident 52 or their Representatives she did not have explained when the representatives were asked ive the influenza vaccine and pneumococcal vaccine, staining a written consent was provided on the ident or resident d the administration of the 23-2024 season) and de.		383		7/1/24
	LTC facility must deve and procedures to en (i) When COVID-19 v facility, each resident is offered the COVID-	accine is available to the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING		C 06/06/2024	
NAME OF PROVIDER OR SUPPLIER RICH SQUARE NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	•	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 887	immunized; (ii) Before offering Comembers are provided regarding the benefit effects associated with the covided receives education register and potential single the COVID-19 vaccine (iv) In situations where requires multiple dost resident representation provided with current additional doses, included the covided with the covided the resident, resimember has the oppic COVID-19 vaccine, at (vi) The resident's medicumentation that in the following: (A) That the resident was provided educated benefits and potential COVID-19 vaccine; at (B) Each dose of CO to the resident; or (C) If the resident did vaccine due to medicumentations or resident and potential contraindications or resident was provided to medicumentation that in the following: (B) Each dose of CO to the resident did vaccine due to medicumentations or resident did vaccine did vaccine of the resident did vaccine due to medicumentations or resident did vaccine did vaccine of the resident did vaccine d	DVID-19 vaccine, all staff ed with education is and risks and potential side the the vaccine; OVID-19 vaccine, each ent representative egarding the benefits and ide effects associated with ne; re COVID-19 vaccination es, the resident, eve, or staff member is a information regarding those luding any changes in the potential side effects coVID-19 vaccine, before or administration of any dent representative, or staff fortunity to accept or refuse a land change their decision; edical record includes indicates, at a minimum, or resident representative ion regarding the il risks associated with and vID-19 vaccine administered in not receive the COVID-19 cal effusal; and tains documentation related ccination that	F 88	7		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345356	B. WING		C 06/06/2024	
NAME OF PROVIDER OR SUPPLIER RICH SQUARE NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869	1 00/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 887	the benefits and pote associated with COV (B) Staff were offere information on obtain (C) The COVID-19 were lated information at Disease Control and Healthcare Safety Northis REQUIREMENT by: Based on record refacility failed to docume the COVID (2023-20 resident's or resident receive the COVID (for 2 of 6 residents or (Resident #41 and Findings included: 1. a. Resident #41 were larger was severely im the coverage of the cove	provided education regarding ential risks //ID-19 vaccine; d the COVID-19 vaccine; and vaccine status of staff and as indicated by the Centers for I Prevention's National etwork (NHSN). T is not met as evidenced view and staff interviews, the ment providing education of 124 season) vaccine and the trepresentative's refusal to 2023-2024 formula) vaccine eviewed for immunizations desident #152). vas admitted to the facility on um Data Set (MDS) ///2024 indicated Resident	F 88		of e	
	documentation Resi Representative had COVID (2023-2024 for administration or	ole to provide written dent #41 or Resident #41's received education for the formula) vaccine to consent refusal of administration of 124 formula) vaccine.		C. What measure will be put in place systemic changes made to ensure that the identified issue does not occur in the future? On 06/20/2024, the Director of Nursing and the Nurse Management to were re-educated on the Covid 19	e or t he	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345356	B. WING		C 06/06/2024	
NAME OF PROVIDER OR SUPPLIER RICH SQUARE NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 887	A review of Resident record (EMR) report COVID vaccine. There was no docur or Resident #152's leducation to conser (2023-2024 formula) There was no docur Resident #152 had (2023-2024 formula) The quarterly Minimassessment dated 4 #152 was severely in the facility was unadocumentation Resident #152 was severely in the facility was unadocumentation Resident Representative had COVID (2023-2024 for administration or the COVID (2023-2024 for administration or the facility on 11/30/COVID (2023-2024 and administered to representatives priofacility. She explaint resident representatives	as admitted to the facility on at #152's electronic medical ted on 1/4/2023 refusal for the mentation that Resident #152 Representative was provided at or refuse the COVID) vaccine. mentation in the EMR received the COVID vaccine	F 887	immunization policy and procedure the Clinical Nurse Consultant. D. Indicate how facility plans to r its performance to make sure that is achieved and sustained: The Dir Nursing/designee will audit new admissions 5 times a week for 12 v. To ensure residents were provided education and offered the the Co-v Immunization and any declination is The Nursing Home Administrator/designee will bring rethe audits to be reviewed in Quality assurance performance Indicator in for 3 months or longer if QAPI com deems necessary.	monitor solution ector of veeks. id 19 signed. esults of	

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345356	B. WING		C 06/06/2024	
NAME OF PROVIDER OR SUPPLIER RICH SQUARE NURSING & REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 300 NORTH MAIN STREET RICH SQUARE, NC 27869		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 887	resident representativ		F 88	37		