	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С	
		345277	B. WING		09/06/2024	
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOI	RO REHABILITATION AN	D HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 000	Initial Comments		E 000			
F 000	survey was conducte The facility was found requirement CFR 483 Preparedness. Even	t ID# GBV611.	F 000			
	conducted from 9/3/2 GBV611. The followi NC00219335, NC002 NC00220084, NC002 NC00215410, NC002 0 of the 21 complaint	complaint survey was 4 through 9/6/24. Event ID# ng intakes were investigated 215777, NC00203461, 211308, NC00216141, 213122 and NC00203469. allegations resulted in				
F 641 SS=B	, ,	nents	F 641		9/30/24	
	resident's status. This REQUIREMENT by: Based on record rev interviews, the facility Data Set (MDS) asse areas of range of mo medications and PAS Screening and Resid This was for 2 of 21 r The findings included 1. Resident #21 was	at accurately reflect the F is not met as evidenced iews, observations and staff r failed to code the Minimum essment accurately in the tion (Resident #21), SRR (Pre-Admission ent Review- Resident #36). residents reviewed.		F 641 Accuracy of Assessments 1. Resident #21, MDS was modified to reflect Functional Limitations of Range of Motion of Impairment to Lowe Extremity on both sides. Resident #36, MDS was modified to reflect Level II PASRR conditions: Seric Mental Illness. Resident # 36, MDS was modified to reflect Antipsychotic medication use and identification.	us	

Electronically Signed

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

09/25/2024

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			OMB N	M APPROVE 0. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		E SURVEY PLETED
		345277	B. WING		09	C / 06/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	PCODE	
ASHEBORO REHABILITATION AND HEALTHCARE CENTER			400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 641	Continued From page	e 1	F 64	41		
	An orthonedic progre	ess note dated 6/26/24				
		ent #21 had contractures		2. All residents with Fur	nctional	
		d right lower extremity.		Limitations of Range of I		
		- ,		PASRR Qualified conditi		
		essment dated 8/10/24		receiving psychotherape		
		21 had intact cognition and		have the potential to be		
		ed range of motion to one		house lookback audit of		
	side of the upper and	l lower extremity.		Functional Limitations of Level II PASRR Qualified	-	
	An interview occurred	d with the MDS Nurse on		those receiving psychoth		
		he reviewed the MDS		medications was comple		
		10/24 and indicated it was		Leadership designee on	-	
	an oversight not to ha	ave coded Resident #21 with		house lookback audit of		
	limited range of motion	on to both lower extremities.		MDS coding of residents Limitations of Range of I		
	On 9/4/24 at 1:00 PM	1, an observation occurred		PASRR Qualified conditi	ions and those	
		no was unable to move her		receiving psychotherape		
		g remained in a straight		for Identification of resid		
		contracture to the left leg		Functional Limitations of	-	
	foot drop was also pr	e to straighten out and right		Level II PASRR Qualified those receiving psychoth		
		coont.		medications was comple		
	On 9/6/24 at 9:14 AM	1, the Administrator was		Leadership designee on	-	
		d it was his expectation for				
		ts to be coded accurately.		3. Education was comp		
		as admitted to the facility on		9/25/24 by Nurse Practic		
		sis that included major		designee for licensed nu		
	depressive disorder a	ana schizophrenia.		Part-time, PRN and Age and weekends and for M		
	Review of Resident #	#36's physician orders		(MDS) Coordinator rega		
		iated on 11/6/23 for an		Minimum Data Set (MDS	-	
		tion to be given two times		identification and coding		
	daily.	~		Limitations of Range of I		
			Minimum Data Set (MDS	S) Coordinator		
	A review of the July 2			and Social Services Dire		
		d revealed Resident #36		and coding of Level II PA		
	was administered ant	tipsychotic medication daily.		Minimum Data Set (MDS		
				identification and coding	UI	

Facility ID: 923365

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/01/20 FORM APPROVE OMB NO. 0938-039
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345277	B. WING		C 09/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEBOF	RO REHABILITATION AN	ID HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIO
F 641	dated 7/9/24 indicate was cognitively impa section was coded th antipsychotic medica back period. On 9/5/24 at 3:28 PM the MDS nurse. She completed the medic and did not code the usage section correct oversight. b. A review of the PA notice dated 3/1/24 in approved for a Level A review of the Resid assessment dated 07 #36 had a diagnosis considered by the sta Screening and Resid process to have a se intellectual disability On 9/5/24 at 12:30 P with the Social Work the facility received r from a Level I to a Le but did not code it co She further indicated An interview was cor with the Administrato MDS assessments s resident's status.	Date Set (MDS) assessment of Resident #36's cognition ired. The medications hat she did not receive tion during the 7 -day look A, an interview occurred with explained she had ation section of the MDS antipsychotic medication tly and that it was an SRR Level II determination indicated Resident #36 was II PASRR. dent 36's annual MDS 7/9/24 indicated Resident of Schizophrenia but was not ate level II Preadmission lent Review (PASRR) rious mental illness and/or or a related condition M, an interview occurred er, and she explained that notification of the change evel II PASRR in March 2024 rrectly on the annual MDS. that it was an oversight. mpleted on 9/6/24 at 9:23 AM r and he indicated that the hould accurately reflect the	F 64	 Psychotherapeutic medication usage Ongoing education to be completed during New Employee Orientation an Annual Education. 4. The Director of Nursing designee complete an audit of all residents for Contractures and or Functional Limitations of Range of Motion, resid with Level II PASRR Qualified condit medication usage and Minimum Data (MDS) coding accuracy of assessme Functional Limitations of Range of M residents with Level II PASRR and Psychotherapeutic medication usage weekly x 4 weeks to begin 9/13/24, t bi-weekly x2 weeks, then monthly x month. Results of these audits will be brought before the Quality Assurance Performance Improvement committe (QAPI) for any additional monitoring modification of this plan monthly for 3 months for additional recommendation and to ensure the facility remains in compliance. Director of Nursing will be responsible implementation of the plan. 	nd will lents ions, a Set ent for lotion, e hen 1 e e e e e or 3 cons le for
F 657 SS=D	Care Plan Timing and	d Revision	F 65	7	9/30/24

Facility ID: 923365

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PRINTED: 10/01/2024 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROV MB NO. 0938-03	/ED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345277	B. WING			C 09/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, Z			
ASHEBOR	RO REHABILITATION AN	D HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT	E (X5) COMPLETIC DATE	N
F 657	CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an inf includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the r An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by th (iii)Reviewed and revi team after each asse comprehensive and q assessments. This REQUIREMENT by: Based on record revise reflect a resident's lev	(i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that hited to /sician. e with responsibility for the responsibility for the 1 and nutrition services staff. tricable, the participation of resident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the juarterly review * is not met as evidenced wand staff interviews the e a smoking care plan to vel of supervision needed for sidents (Resident #77)	F	F 657 Care plan Timing 1. Resident # 77, Care to reflect independent si 2. All resident smokers to be affected. A whole I audit of all resident smo	Plan was update moking status. have the potenti house lookback		
				completed by Nurse Lea		e	

Event ID: GBV611

Facility ID: 923365

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TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
					С	
		345277	B. WING		09/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOF	RO REHABILITATION AN	ID HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 657	Continued From page	- 4	F 657	7		
		iginally admitted to the facility	1 007	on 9/6/24 for Minimum Data Set (MDS		
	on 7/11/23 with diagn			Coordinator and Nurse identification ar		
	hemiplegia and hemiparesis following cerebral infarction.			care planning of residents smoking sta	tus.	
				3. Education was completed on or bef	ore	
		77's quarterly smoking 8/24 revealed the resident		9/25/24 by Nurse Practice Educator or		
	was a safe smoker a			designee for licensed nurses (Full-time Part-time, PRN and Agency) on all shif		
	supervision.			and weekends and Minimum Data Set		
				(MDS) Coordinator regarding Nurse an	d	
		77's quarterly Minimum		Minimum Data Set (MDS) Coordinator		
		d 7/2/24 revealed the		identification and care planning of all		
		ely impaired and required for most activities of daily		resident smokers smoking status. Ongoing education to be completed		
	living (ADL).	for most douvlies of daily		during New Employee Orientation and Annual Education.		
		77's care plan revised on				
	7/5/24 revealed the rown when smoking.	esident required supervision		 The Director of Nursing designee w complete an audit of all resident smoke and smoking status, weekly x 4 weeks 	ers	
	An interview with the	MDS coordinator on 9/4/24		begin 9/13/24, then bi-weekly x2 weeks		
		Residents #77's care plan		then monthly x 1 month. Results of the		
	should have reflected	the resident being an		audits will be brought before the Quali		
	independent smoker			Assurance Performance Improvement		
	smoking assessment	was completed on 5/8/24.		Committee (QAPI) for any additional monitoring or modification of this plan		
	An interview conduct	ed with the Administrator on		monthly for 3 months for additional		
		vealed Resident #77's care		recommendations and to ensure the		
	resident was an inde	-		facility remains in compliance.		
		revealed resident care plans care and concerns and were		Director of Nursing will be responsible implementation of the plan.	for	
F 658 SS=D		eet Professional Standards	F 658	3	9/30/24	
	§483.21(b)(3) Compr	ehensive Care Plans d or arranged by the facility,				

Facility ID: 923365

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 10/01/202 APPROVE . 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		345277	B. WING			<i>,</i>)6/2024
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COL	DE	
ASHEBOR	O REHABILITATION AN	D HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203		
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 658	Continued From page	e 5	F 658			
1 000		mprehensive care plan,	1 000			
	must-	inprenensive care plan,				
	(i) Meet professional This REQUIREMENT	standards of quality. is not met as evidenced				
	by: Based on record revi	iew and staff interviews, the		F 658 Services Provided Me	et	
		cribe the correct medication		Professional Standard		
	•	or 1 of 1 resident reviewed				
	for gastric feeding tub	be (Resident #45).		1. Resident # 45, Care Plan	and order	
				were updated to reflect NPO		
	The findings included	1:		feeding tube route of nutrition	n, fluid and	
	B			medication administration.		
		mitted to the facility on				
	brain injury, history of	es that included traumatic		2. All residents who receive fluids and medications through		
		and presence of a feeding		feeding tube as route of adm	-	
	tube.	and presence of a recurry		have the potential to be affect		
				house lookback audit of all re		
	An annual Minimum	Data Set (MDS) assessment		receive nutrition, fluids and m	nedications	
		ed Resident #45 had severe		through gastric feeding tube		
	cognitive impairment	and received all nutrition		administration was completed	d by Nurse	
	and fluids via a feedir	ng tube.		Leadership designee on 9/6/2		
				Minimum Data set (MDS) Co		
		care plan, last reviewed		Nurse identification and care		
		sident #45 required tube		residents who receive nutritic		
	feeding for all nutrition	n and fluids.		medications through gastric f as route of administration.	eeding tube	
	The active Sentembe	r 2024 physician orders				
	-	ed 6/20/24 for Guaifenesin				
		per 5 milliliters. Give 20		3. Education was completed	on or before	
	milliliters by mouth th	•		9/25/24 by Nurse Practice Ed		
	U	Il other medications were		designee for licensed nurses		
	-	I through the gastric feeding		Part-time, PRN and Agency)		
		orders indicated Resident		and weekends and Minimum		
	#45 was to have noth	ning by mouth (NPO).		(MDS) Coordinator regarding		
	On 9/5/24 at 10:18 Al	M an interview was		Minimum Data Set (MDS) ide and care planning of all resid		
		e #1 who was working the		receive nutrition, fluids and m		
		an a who was working the	1		iouloulou3	

Facility ID: 923365

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TATEMENT C	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
		345277	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	09/06/2024
				400 VISION DRIVE	
ASHEBOR	O REHABILITATION AN	D HEALTHCARE CENTER		ASHEBORO, NC 27203	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
	confirmed Resident # medications by mouth her morning dose of 0 Nurse #1 acknowledg Administration Recor Guaifenesin to be pro- inaccurate as all medi the gastric feeding tu The Assistant Director interviewed on 9/5/24 Resident #45's physic the route for Guaifene instead of via gastros tube). She further exp medication into the exi- default route was ora oversight that the nur to G-tube. The ADON expectation for all me routes to be entered of received and verified A phone interview oc 9/6/24 at 10:13 AM. Sverified the Guaifene on 6/20/24. Nurse #2 the order after it had Practitioner in the Ele- failed to change the r gastrostomy tube. SI was by mouth. Drug Regimen Revie CFR(s): 483.45(c)(1)	dications earlier. The nurse 445 did not receive any h and she had not provided Guaifenesin by mouth. ged the Medication d (MAR) read for ovided by mouth, which was lications were provided via be. or of Nursing (ADON) was 4 at 2:14 PM. She reviewed cian orders and confirmed esin was entered as oral stomy tube (G-tube/feeding blained when entering the lectronic medical system the I, and she felt it was an se failed to change the route N stated it was her edication administration correctly when the order was curred with Nurse #2 on She was the nurse that sin order for Resident #45 rexplained that she verified been entered by the Nurse ectronic Medical System but medication route to he stated the default route w, Report Irregular, Act On (2)(4)(5)	F 658	 administration. Ongoing education to completed during New Employee Orientation and Annual Education. 4. The Director of Nursing designee we complete an audit of all residents where receive nutrition, fluids and medication through gastric feeding tube as route administration and Minimum Data Set (MDS) Coordinator care planning accuracy weekly x 4 weeks to begin 9/13/24, then bi-weekly x2 weeks, the monthly x 1 month. Results of these audits will be brought before the Qual Assurance Performance Improvemen Committee (QAPI) for any additional monitoring or modification of this plan monthly for 3 months for additional recommendations and to ensure the facility remains in compliance. Director of Nursing will be responsible implementation of the plan. 	vill ons of i i t t
	§483.45(c) Drug Reg §483.45(c)(1) The dru	imen Review. ug regimen of each resident			

Facility ID: 923365

If continuation sheet Page 7 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/01/2024 MAPPROVED). 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ISTRUCTION	(X3) DATE COMP	SURVEY LETED
		345277	B. WING				C 06/2024
NAME OF PR	OVIDER OR SUPPLIER	•		STREE	T ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOR	ASHEBORO REHABILITATION AND HEALTHCARE CENTER				SION DRIVE BORO, NC 27203		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 756	Continued From page	e 7	F 7	56			
		east once a month by a					
	§483.45(c)(2) This re of the resident's medi	view must include a review ical chart.					
	irregularities to the at	armacist must report any tending physician and the					
	and these reports mu	ctor and director of nursing, st be acted upon.					
	(i) Irregularities inclue	de, but are not limited to, any					
	-	riteria set forth in paragraph an unnecessary drug.					
	(ii) Any irregularities r	noted by the pharmacist					
	during this review mu separate, written repo	st be documented on a					
		nd the facility's medical					
	director and director of	of nursing and lists, at a					
		nt's name, the relevant drug, e pharmacist identified.					
		sician must document in the					
	resident's medical rec	cord that the identified					
	• •	reviewed and what, if any, n to address it. If there is to					
		nedication, the attending					
	physician should doci	ument his or her rationale in					
	the resident's medica	I record.					
	§483.45(c)(5) The fac	cility must develop and					
	-	procedures for the monthly					
		that include, but are not s for the different steps in					
		s the pharmacist must take					
	when he or she identi	ifies an irregularity that					
	•	n to protect the resident.					
	by:	is not met as evidenced					
	Based on record revi	iew and interviews with staff, t and Nurse Practitioner, the			756 Drug Regimen, Review, Repor egular, Act On	t	

Facility ID: 923365

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			A BOILDING		с
		345277	B. WING		09/06/2024
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE	•
		D HEALTHCARE CENTER		400 VISION DRIVE	
ASILLEOI		D HEALINGARE CENTER		ASHEBORO, NC 27203	
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETI
F 756	Continued From page	e 8	F 75	56	
	Pharmacy Consultan			1. Resident # 73, Pharmacy identi	fied
	facility's need to ident	-		psychotropic medication (antipsych	
	-	r those symptoms as well as		antianxiety, hypnotic and antidepre	
		esidents for side effects of		target behaviors and initiated plan	
		tions (Residents #73, #82		monitor target behaviors on Pharm	acist
		or 3 of 5 residents reviewed		Review and or on the Pharmacist I	
	for unnecessary med	ications.		Mediation Regim Review (IMRR);	Facility
				identified psychotropic medication	
	The findings included	l:		(antipsychotic, antianxiety, hypnoti	
	1 Decident #70			antidepressant) target behaviors a	
		originally admitted to the		initiated plan to monitor target beha	
	-	h a recent readmission date oses included bipolar		with behavior monitoring and side orders initiated in PCC web application	
	disorder, depression,	•		9/6/24.	
	unspecified psychotic			0.0.21	
				Resident # 82, Pharmacy identified	ł
	A review of Resident	#73's medical record		psychotropic medication (antipsych	
		g hospitalization for mental		antianxiety, hypnotic and antidepre	
	health concerns:			target behaviors and initiated plan	
	-	2/12/24 was seen for suicidal		monitor target behaviors on Pharm	
	ideations.			Review and or on the Pharmacist I	
	-	4/23/24 was seen for bipolar		Mediation Regim Review (IMRR);	Facility
	disorder severe with	psychotic features.		identified psychotropic medication	a and
	A review of Resident	#73's physician orders		(antipsychotic, antianxiety, hypnoti antidepressant) target behaviors a	
		ted 4/25/24 for Fluphenazine		initiated plan to monitor target behaviors a	
		dication) 5 milligrams (mg)		with behavior monitoring and side	
	one tablet by mouth t	, , , , , , , , , , , , , , , , , , , ,		orders initiated in PCC web applica	
				9/6/24.	
	A quarterly Minimum	. ,			
		29/24 indicated Resident		Resident # 68, Pharmacy identified	
		ntact and displayed no		psychotropic medication (antipsych	
		mood was coded with		antianxiety, hypnotic and antidepre	
		sed or hopeless 7 out of 10		target behaviors and initiated plan	
	days during the 14-da Resident #73 receive	-		monitor target behaviors on Pharm Review and or on the Pharmacist I	
	medication.	น ลา ลาแครงเทยแบ		Mediation Regim Review (IMRR);	
				identified psychotropic medication	
	Poviow of the Pharm	acy Consultant medication		(antipsychotic, antianxiety, hypnoti	c and

Facility ID: 923365

If continuation sheet Page 9 of 29

TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		C
		345277	B. WING		09/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ASHEBOF	O REHABILITATION AN	D HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIO
F 756	Continued From page	9	F 756	6	
	7/12/24 and 8/15/24, monitoring targeted b the use of an antipsyc A psychiatric progress Resident #73 endorse depression, irritability A review of Resident notes from 2/1/24 to 9 such as crying, suicid restlessness. Resident #73's Medic Records (MAR) from she received Fluphen did not list any targete for staff to monitor. An interview with Nur on 9/4/24 at 2:09 PM expected the Pharma caught the missing ta	s note dated 8/6/24 indicated ed having more episodes of and anxiety. #73's nursing progress 9/3/24 included behaviors lal thoughts, agitation, and		 antidepressant) target behaviors and initiated plan to monitor target behaviors and initiated plan to monitor target behaviors initiated in PCC web applicates 9/6/24. 2. All residents receiving psychotherapeutic medications have potential to be affected. A whole have potential to ensure identification of target behaviors and initiation of platmonitor target behaviors were notee Point Click Care (PCC) and on the Pharmacist Interim Mediation Regil Review (IMRR) was completed by Leadership designee on 9/6/24 for MDS/Nurse identification and care planning of target behaviors and in of plan to monitor target behaviors and in of plan to monitor target behaviors. 3. Education was completed on or 9/25/24 by Nurse Practice Educator 	aviors effects ation on ve the buse eiving s of an to ed in Murse itiation of
	Pharmacy Consultant stated she didn't norm reviewed the physicia notes as well as the r during her medication Consultant stated she behaviors and side ef important in a resider	nt with a history of suicidal acy Consultant was unable		designee for licensed nurses (Full- Part-time, PRN and Agency) on all and weekends and Pharmacist reg Nurse and Pharmacist identification target behaviors and initiation of pla monitor target behaviors on Pharm Review and or on the Pharmacist I Mediation Regim Review Pharmac Review (IMRR) and in Point Click ((PCC). Ongoing education to be completed during New Employee	shifts arding n of an to acist nterim ist

Facility ID: 923365

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						RM APPROVI 10. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED C
		345277	B. WING	·····	0	9/06/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
ASHEBOR	O REHABILITATION AN	ID HEALTHCARE CENTER		400 VISION DRIVE		
				ASHEBORO, NC 27203		
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 756	Continued From page	e 10	F 7	56		
	monitoring for Reside					
	recommendations.			4. The Director of Nursing	designee will	
		admitted on 10/27/23 with		complete an audit of all resi		
	cumulative diagnose dementia with behav	s of depression anxiety,		receiving psychotherapeution with identification of target to		
	unspecified psychosi			initiation of plan to monitor t		
	disorder.			behaviors documented in P	•	
				(PCC) and on the Pharmac		
		um Data Set (MDS) dated		or on the Pharmacist Interin		
		ident #82 had moderate		Regim Review Pharmacist		
		, exhibited no behaviors and e of an antipsychotic and an		(IMRR) weekly x 4 weeks to 9/13/24, then bi-weekly x2 v	•	
	antidepressant.			monthly x 1 month. Results		
	•			audits will be brought before		
	Review of Resident #	-		Assurance Performance Im		
		uded the following order		Committee (QAPI) for any a		
		quel (antipsychotic) Extended milligrams give one tablet by		monitoring or modification of monthly for 3 months for ad	•	
	mouth in the afternoo			recommendations and to er		
		irbances. Another order		facility remains in compliant	ce.	
		ertraline (antidepressant) 50				
		ablet by mouth at bedtime for iors, depression and anxiety.		Director of Nursing will be ruint implementation of the plan.		
		ation administration records				
	· · ·	ber 1, 2023 to September				
		der that was not included on				
	the monthly Physicia resident free from side					
		edications? (if no, document				
	side effects in progre	ess note every shift-Order				
		ere was no documented				
	evidence of targeted					
		clarification of what side to monitor with regard to the				
	antipsychotic versus	-				
	A review of a Pharma	acist Medication Regime				
	Review dated 11/20/2	-				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/01/2024 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345277	B. WING				C 106/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOR		D HEALTHCARE CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
(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 756	irregularities and no review was completed Pharmacist. A review of Pharmacia Review dated 12/15/2 report for any noted in completed by the prevent Pharmacist. The moni- requested from the Ass (ADON) on 9/4/24 but the December pharma- was not able to locate recommendations dat A review of a Pharma- review dated 1/19/24 irregularities and no re- review was completed Pharmacist. A review of a Pharma- review dated 2/23/24 irregularities and no re- review was completed Pharmacist. A review of a Pharma- review dated 3/15/24 irregularities and no re- review was completed Pharmacist. A review of a Pharma- review dated 3/15/24 irregularities and no re- review was completed Pharmacist. A review of a Pharma- review dated 3/15/24 irregularities and no re- review was completed Pharmacist. A review of a Pharma- review dated 4/24/24 recommendations and This review was completed Pharmacist.	ecommendations. This d by the previous Consultant ist Medication Regime 23 read to see the monthly rregularities. This review was vious Consultant thly pharmacy reports were ssistant Director of Nursing t there was nothing listed on acy report and the ADON e any pharmacy ted 12/15/23. Acist Medication Regime read there were no ecommendations. This d by the previous Consultant acist Medication Regime read there were no ecommendations. This d by the current Consultant acist Medication Regime read there were no ecommendations. This d by the current Consultant acist Medication Regime read there were no ecommendations. This d by the current Consultant	F	756			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	D. 0938-0391 SURVEY PLETED	
		345277	B. WING				C 106/2024	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
ASHEBO	RO REHABILITATION AN	D HEALTHCARE CENTER			00 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	to add a stop date of Resident #82's as ne- because they must be reevaluated. A review of a Pharma review dated 5/29/24 irregularities and no r review was completed Pharmacist. A review of a Pharma review dated 6/28/24 irregularities and no r review was completed Pharmacist. A review of a Pharma review dated 7/13/24 recommendations an Review of the monthl recommendation was dose reduction on Re This review was completed Pharmacist A review of a Pharma review dated 7/13/24 recommendation was dose reduction on Re This review was completed Pharmacist. A review of a Pharma review dated 8/16/24 irregularities and no r review was completed Pharmacist. An interview was completed Pharmacist.	5/20/24 to the use of eded (prn) antipsychotic e limited to 14 days and acist Medication Regime read there were no ecommendations. This d by the current Consultant acist Medication Regime read there were no ecommendations. This d by the current Consultant acist Medication Regime read there were d to see the monthly report. y pharmacy report read her to attempted a gradual esident #82's antidepressant. pleted by the current st. cost Medication Regime read there were no ecommendations. This d by the current st. acist Medication Regime read there were no ecommendations. This d by the current ant st. cost Medication Regime read there were no ecommendations. This d by the current Consultant	F	756				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345277	B. WING				C 06/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ASHEBO	RO REHABILITATION AN	D HEALTHCARE CENTER			00 VISION DRIVE SHEBORO, NC 27203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	prolonged use of an a and no drowsiness, d headaches symptoms antidepressants. An interview was corr with the ADON who w Nursing (DON) while the Consultant Pharm #82's medications for completeness every r documentation from t stating the need to ide behaviors or specific different psychotropic stated either the DON monthly pharmacy rej for all the residents an monthly reports going that mentioned anythin monitoring needed or An interview was corr with NP #1. She state the Consultant Pharm missing monitoring ar happening since Nove concerned for all the psychotropic medicat reguire close monitor behaviors to determin improved or not and t free from adverse sid An interview was corr AM with Nursing Assi	antipsychotic medications izziness, insomnia or a associated with appleted on 9/4/24 at 1:54 PM vas acting as the Director of she was away. She stated hacist reviewed Resident irregularities, accuracy and month and there was no he Consultant Pharmacist entify her target clinical side effect monitoring for medications. The ADON I or herself reviewed the ports and recommendations and there was nothing in the back to November 2023 ing about the missing n Resident #82. appleted on 9/4/24 at 2:09 PM ed she would have expected hacist to have caught the nd since it had been ember 2023, she was residents prescribed ions. NP #1 stated when are prescribed her psychotropics, they ing for target clinical he if the identified behaviors o see if the resident remains	F	756			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY LETED
		345277	B. WING				06/2024
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
ASHEBO	RO REHABILITATION AN	D HEALTHCARE CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 756	and she was never kr of negative behaviors was always cooperati An interview was com AM with Nurse #3. Sh sometime after her ac she was "sundowning Resident #82's behav control for months. A telephone interview previous Consultant F exit, she had not retur A telephone interview 3:20 PM with the Con stated when she com medication review, sh the MARs to see if the behaviors but rather sinursing and Psychiatur reviewing Resident #4 a box to check for bel monitoring at all, she missing monitoring was behaviors were impor worsening or improve antidepressants and a side effects and both potential adverse side stated she started in 1 should have identified on it before the now.	nown her to exhibit any sort NA #1 stated Resident #82 ve and pleasant with her. Appleted on 9/5/24 at 10:40 he stated at one time dmission, it was suspected g"(late-day confusion) but riors have been under a was attempted with the Pharmacist but at the time of rned surveyor's calls. T was completed on 9/5/24 at usultant Pharmacist. She pletes her monthly he does not normally review are have been any she reviews Physician, NP, ric notes. She stated after 82's MARs and only seeing haviors and no side effect understood what the as and why target clinical tant to identify to determine ment. She stated both antipsychotics have different should be clear on what a effects to monitor. She February 2024 and that she d this irregularity and acted pleted on 9/5/24 at 3:50 PM T. He stated the Consultant reviewing Resident #82's	F	756			

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	-	D HUMAN SERVICES				FORM	MAPPROVED
	S FOR MEDICARE & I		(X2) MUU	וחו	LE CONSTRUCTION	(X3) DATE	D. 0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					PLETED
							с
		345277	B. WING			09/	/06/2024
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOR	O REHABILITATION ANI	D HEALTHCARE CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
					,		0(5)
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
F 756	Continued From page	e 15	F	756	6		
		t was hard to imagine that		100			
		ant Pharmacist and the					
		armacist did not identify the					
	missing monitoring ne	eded for the use of ions. He stated he expected					
	better from the Consu	•					
		-					
		originally admitted to the					
		th diagnoses that included isorder, major depressive					
	disorder, delusional d						
	disease with late onse	et, and unspecified					
	psychosis.						
	A review of Resident	#68's physician orders					
		ed 6/27/24 for Olanzapine					
		lication) 10 milligrams (mg)					
	half a tablet by mouth order dated 6/26/24 fo	twice a day and a physician					
		ation) 25 milligrams (mg)					
	one tablet by mouth ty	, _ , _,					
	A () A4 ()						
	A quarterly Minimum	Data Set (MDS) 27/24 indicated Resident					
		npaired and displayed					
	behaviors of physical,	verbal abuse, and					
	•	d was coded with feeling					
		opeless 7 out of 11 days k back period. Resident #68					
	received antipsychotic	•					
	medication.	·					
	Povious of the Dhames	any Consultant mediaction					
		acy Consultant medication dent #68 from 6/1/24 to					
		the need for monitoring					
	targeted behaviors an	nd side effects for the use of					
	an antipsychotic medi	ication.					
	A review of Resident	#68's social service					

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 10/01/2024 RM APPROVED IO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED
		345277	B. WING		0	C 9/06/2024
NAME OF PF	ROVIDER OR SUPPLIER		- I T	ODE	0,00,2024	
ASHEBOR	O REHABILITATION AN	D HEALTHCARE CENTER		400 VISION DRIVE		
				ASHEBORO, NC 27203		
(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 ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	#68 has had an incre included yelling, agita members and delusio Resident #68's Medio Records (MAR) from	7/24/24 indicated Resident ase in behaviors which ation, aggression with family ons.	F 75	56		
	ordered. The MAR di behaviors or side effe An interview with Nur on 9/4/24 at 2:09 PM expected the Pharma caught the missing ta	d not list any targeted ects for staff to monitor. rse Practitioner #1 occurred and stated she would have acy Consultant to have arget behaviors and side Resident #68's psychotropic				
	Pharmacy Consultant stated she didn't norm reviewed the physicial notes as well as the r during her medication Consultant stated she behaviors and side et important in a resider behaviors. The Pharm to explain why she di to identify target behavior monitoring for Resider recommendations.	nt with a history of mood and macy Consultant was unable d not recommend the need aviors and side effect ent #68 in her				
	CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(c)(3) A psych		F 75	58		9/30/24

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP		
		345277	B. WING			09/06/2024		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
ASHEBOR	RO REHABILITATION AN	D HEALTHCARE CENTER			100 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 758	processes and behav but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehe resident, the facility m §483.45(e)(1) Reside psychotropic drugs ar unless the medication specific condition as o in the clinical record; §483.45(e)(2) Reside drugs receive gradua behavioral interventio contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs pu unless that medicatio diagnosed specific co in the clinical record; §483.45(e)(4) PRN on are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o	ior. These drugs include, drugs in the following ensive assessment of a nust ensure that nts who have not used re not given these drugs n is necessary to treat a diagnosed and documented nts who use psychotropic dose reductions, and ns, unless clinically effort to discontinue these nts do not receive ursuant to a PRN order n is necessary to treat a undition that is documented and rders for psychotropic drugs . Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and	F	758				

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ATEMENT O	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345277	B. WING		C 09/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	
				400 VISION DRIVE	
ASHEBOR	O REHABILITATION AN	D HEALTHCARE CENTER		ASHEBORO, NC 27203	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLE THE APPROPRIATE DATE
F 758	Continued From page	e 18	F 7	58	
	§483.45(e)(5) PRN o	rders for anti-psychotic			
		4 days and cannot be			
	renewed unless the a	-			
		er evaluates the resident for			
	the appropriateness of				
		is not met as evidenced			
	by:				
		iew, staff, Administrator,		F 758 Free from Unneces	
	resident, Nurse Pract			Psychotropic Meds/PRN l	Jse
		st interviews, the facility		1 Decident # 92 Decrma	any identified
	•	argeted clinical behaviors monitored for the use of		1. Resident # 82, Pharma psychotherapeutic medica	
		ions for Resident's #82, #73		(antipsychotic, antianxiety	
		also failed to complete a		antidepressant) target ber	
		voluntary movement scale		initiated plan to monitor ta	
		tion of a newly prescribed		on Pharmacy Review/ Inte	-
		ident #145. This was for 4 of		Regimen Review; Facility	
	5 residents reviewed	for unnecessary		psychotropic medication (antipsychotic,
	medications. The find	lings included:		antianxiety, hypnotic and	antidepressant)
				target behaviors and initia	-
		admitted on 10/27/23 with		monitor target behaviors v	
	•	s of depression anxiety,		monitoring and side effect	
	dementia with behavi			initiated in Point Click Car	e (PCC)web
	unspecified psychosis disorder.	s and allective mood		application on 9/6/24.	
				Resident #145, AIMS Bas	e line
	The quarterly Minimu	m Data Set (MDS) dated		Assessment was initiated	
		dent #82 had moderate		on 9/4/24.	
		exhibited no behaviors and		Resident #73, Pharmacy i	dentified
	•	e of an antipsychotic and an		psychotherapeutic medica	
	antidepressant.			(antipsychotic, antianxiety	
				antidepressant) target beh	
		82's comprehensive care		initiated plan to monitor ta	•
		initiated on 10/30/23 and		on Pharmacy Review/ Inte	
	revised on 2/26/24 th			Regimen Review; Facility	
		sk for distressed, fluctuating		psychotropic medication (antianxiety, hypnotic and	
		LOG TO GODTOCCIOD ODVIOTU	1	antianxiety hypnotic and a	anugenressant)
	and affective disorder	ted to depression, anxiety		target behaviors and initia	

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		MEDICAID SERVICES				IO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
					С	
		345277	B. WING		0	9/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
ASHEBO	RO REHABILITATION AN	ID HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 758	Continued From pag	e 19	F 75	8		
F 730	2/26/24 for complicat psychotropic drugs (antidepressant/antip included AIMS testing behavior monitoring, needed, monitor for functional level and r indicated, monitor for medication as related and lastly to monitor the Physician and/or Review of Resident # included the following Seroquel (antipsycho hour 50 milligrams gi afternoon for dement disturbances. Anothe Sertraline (antidepres	tions related to the use of esychotic). Interventions g per protocol, complete gradual dose reductions as changes in mental status and eport to the Physician as the continued need of the d to her behaviors and mood for side effects and consult Pharmacist as needed. #82's Physician orders g order dated 4/23/24: btic) Extended Release 24 ve one tablet by mouth in the tia with mood/psychotic er order dated 8/1/24 read ssant) 50 milligrams give one edtime for dementia with	F 75	 monitoring and side effects initiated in Point Click Care application on 9/6/24. Resident #68, Pharmacy id psychotherapeutic medicat (antipsychotic, antianxiety, antidepressant) target beha initiated plan to monitor targ on Pharmacy Review/ Inter Regimen Review; Facility id psychotropic medication (a antianxiety, hypnotic and a target behaviors and initiate monitor target behaviors wi monitoring and side effects initiated in Point Click Care application on 9/6/24. All residents receiving psychotherapeutic medicate potential to be affected. A version 	e (PCC)web dentified ion hypnotic and aviors and get behaviors rim Medication dentified ntipsychotic, ntidepressant) ed plan to ith behavior a orders e (PCC)web	
	Review of the medica (MARs) from Novem 2024 included an ord the monthly Physicia resident free from side psychotherapeutic m side effects in progree Date 11/10/2023. The evidence of targeted identification and no effects the staff were antipsychotic versus Review of Resident # November 1, 2023, to include 3 nursing not	ation administration records ber 1, 2023 to September der that was not included on n orders that read: Is le effects of edications? (if no, document ss note every shift-Order ere was no documented clinical behavior clarification of what side to monitor with regard to the		look back audit of all reside psychotherapeutic medicat completed to ensure both a was completed on admission six months and identification behaviors and initiation of p target behaviors were note Care (PCC) and on the Phar Medication Regim Review house audit completed by I Leadership designee on 9// Coordinator, Nurse, and Ph identification, care planning behaviors and initiation of p target behaviors of those re- receiving psychotherapeuti	ents receiving ions was a Baseline AIMs on and every on of target blan to monitor d in Point Click armacist macist Interim (IMRR) Whole Nurse 6/24 for MDS harmacist g of target blan to monitor esidents	

Facility ID: 923365

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION	· · · ·	E SURVEY PLETED
						С
		345277	B. WING		09	/06/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ASHEBOF	RO REHABILITATION AN	D HEALTHCARE CENTER		400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIC DATE
F 758	Continued From page	e 20	F 75	58		
	UTI's on 2/8/24. An interview was con 9/3/24. She was sittir dressed for the day. S engaging in a conver There were no obser symptoms such as m rigidity, jerking or trer prolonged use of an a and no drowsiness, d headaches symptoms antidepressants. An interview was con with the Assistant Dir who was acting as th while she was away. aware of the need to clinical behaviors who was added and also side effects for psych ADON stated whoeve in November 2023, th behaviors for the anti	c by urology for recurrent npleted with Resident #82 on ng up in her reclining chair She was very pleasant and sation regarding her jewelry. ved extrapyramidal novement dysfunction, mors associated with antipsychotic medications lizziness, insomnia or s associated with npleted on 9/4/24 at 1:54 PM ector of Nursing (ADON) e Director of Nursing (DON) The ADON stated she was identify and monitor target en a psychotropic medication needed to monitor specific notropic medications. The er entered the original order ney did not check off specific		 3. Education was completed 9/25/24 by Nurse Practices designee for licensed nurse Part-time, PRN and Agenerand weekends, MDS Coor Pharmacist regarding Nure Pharmacist ensuring a Bac completed on admission at months and identification behaviors and initiation of target behaviors on Pharmand or Interim Medication (IMRR) and in Point Click Ongoing education to be eduring New Employee Orie Annual Education. 4. The Director of Nursing complete an audit of all reincluding new admissions psychotherapeutic medication both a Baseline AIMs is complete and every six midentification of target behaviors are documenter Care (PCC) and on the PI Review and or Interim Medication Medication and every for the provide the provide	e Educator or ses (Full-time, cy) on all shifts irdinator and seand aseline AIMs is and every six of target iplan to monitor macist Review Care (PCC). completed ientation and g designee will esidents receiving ations to ensure ompleted on months and haviors and or target d in Point Click harmacist	
	When the order was have checked side ef the antipsychotic and	or the side effect monitoring. entered, the person should ffects to be monitored with I the antidepressant. She rt looking at the residents on tions today.		Review (IMRR) . Audits to weekly x 4 weeks to begin bi-weekly x2 weeks, then month. Results of these a brought before the Quality Performance Improvemen (QAPI) for any additional	n 9/13/24, then monthly x 1 udits will be y Assurance nt Committee	
	with NP #1. She state the facility to have ca	npleted on 9/4/24 at 2:09 PM ed she would have expected ught the error that had been ember 2023 and there was		modification of this plan m months for additional reco and to ensure the facility r compliance.	nonthly for 3 ommendations	

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 10/01/20 FORM APPROVI IB NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>			(X3) DATE SURVEY COMPLETED C		
		345277	B. WING			09/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
ASHEBOR	O REHABILITATION AN	D HEALTHCARE CENTER			00 VISION DRIVE SHEBORO, NC 27203			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 758	Continued From page	e 21	F7	758				
	no excuse because w	when residents in their 90's						
	are prescribed antips	-			Director of Nursing will be responsil	ole for		
	behaviors to determin	equire close monitoring for ne if the identified behaviors d to see if the resident erse side effects.			implementation of the plan.			
	AM with Nursing Assi she had worked with and she was never kn of negative behaviors	npleted on 9/5/24 at10:30 stant (NA) #1. She stated Resident #82 a long time nown her to exhibit any sort s. NA #1 stated Resident #82 ive and pleasant with her.						
	AM with Nurse #3. Sh sometime after her ac she was "sundowning	npleted on 9/5/24 at 10:40 ne stated at one time dmission, it was suspected g"(late-day confusion) but viors have been under						
	with the Administrator prescribed an antipsy psychotropic medicat identification of the ta which the psychotrop Administrator stated n antipsychotics was ne side effects that can of antipsychotics over ti further stated monitor	me. The Administrator ring for side effects with all edications was imperative as						
	diagnoses of vascula	s admitted on 8/13/24 with r dementia, major and a cerebral vascular						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345277	B. WING			09	C / 06/2024
NAME OF PI	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOR	RO REHABILITATION AN	D HEALTHCARE CENTER			400 VISION DRIVE ASHEBORO, NC 27203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 758	8/19/24 indicated Rescognitive impairment He was coded for the Resident #145 was carevised on 8/29/24 for potential to demonstration behaviors related to: a Review of a NP #1 nor report Resident #145 behaviors and agitation Review of a Physician Seroquel (antipsychot tablet every 6 hours a agitation, dementia w 14 days end date 9/1 Review of Resident # medication administration September 2024 MA as needed Seroquel of and 9/4/24. Review of Resident # include a baseline ab movement scale (AIM is an assessment dor	um Data Set (MDS) dated sident #145 had severe and exhibited no behaviors. use of an antidepressant. are planned on 8/22/24 and r exhibiting or had the ate verbal/physical cognitive loss/dementia. Dete dated 8/28/24 read staff was having increased on. In order dated 8/28/24 read tic) 25 milligrams give 1 as needed (prn) for ith behaviors and anxiety x 1/24. In the exercised the on 8/30/24, 9/2/24, 9/3/24 In the exercised the for a sessment. The AIMS ne to determine a baseline ss for involuntary movement	F	758	3		
	with the Assistant Dire	npleted on 9/4/24 at 1:54 PM ector of Nursing (ADON) e Director of Nursing (DON)					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/01/2024 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345277	B. WING		_		C 06/2024
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ASHEBOR	O REHABILITATION AN	D HEALTHCARE CENTER		00 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	under the impression complete the AIMS as #145 was a new adm would check to make answer. An interview was com with NP #1. She state the facility would com the use of a prn antip because she was fam after the 14 days of us needed, the provider needed part of the ord day. She stated when was no baseline AIMS reference point to det was causing adverse On 9/4/24 at 2:43 PM of an AIMS she had c electronic signature b 8/28/24. When asked AIMS to 8/28/24, she it 9/4/24. An interview was com with the Administrator assessment was to be resident was started of medication in order to resident. 3. Resident #73 was of	The ADON stated she was that she had 14 days to seessment since Resident ission. She then stated she sure and return with an appleted on 9/4/24 at 2:09 PM d she would have expected pleted a baseline AIMS for sychotic medication illiar with instances where sing the antipsychotic as often removed the as der and prescribed it every that happens, since there S completed, there is no ermine if the medication side effects over time. , the ADON provided a copy ompleted on 9/4/24 with her ut was back dated to why she back dated the stated she still signed off on appleted on 9/5/24 at 3:50 PM . He stated an AIMS e completed at the time a on an antipsychotic e establish a baseline for that briginally admitted to the n a recent readmission date poses included bipolar anxiety disorder and	F 758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 10/01/20 FORM APPROVI OMB NO. 0938-03			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345277		S (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		345277	B. WING		C 09/06/2024			
NAME OF PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CC				
ASHEBOR	RO REHABILITATION AN	D HEALTHCARE CENTER		VISION DRIVE IEBORO, NC 27203				
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIO HE APPROPRIATE DATE			
F 758	A review of Resident revealed the following health concerns: " 2/10/24 through ideations. " 3/27/24 through disorder severe with A review of Resident included an order dat (an antipsychotic mea- one tablet by mouth the A quarterly Minimum assessment dated 7/2 #73 was cognitively in behavior issues. Her feeling down, depress days during the 14-da Resident #73 receives medication. A psychiatric progress Resident #73 endors depression, irritability A review of Resident reviewed 8/8/24, inclu- areas: " Resident exhibits demonstrate verbal b ineffective coping skil poor impulse control interventions included side effects and resp- behaviors. " Resident is resis mood/psychiatric disc	 #73's medical record g hospitalization for mental 2/12/24 was seen for suicidal 4/23/24 was seen for bipolar psychotic features. #73's physician orders red 4/25/24 for Fluphenazine dication) 5 milligrams (mg) wice a day. Data Set (MDS) 29/24 indicated Resident ntact and displayed no mood was coded with sed or hopeless 7 out of 10 ay look back period. an antipsychotic s note dated 8/6/24 indicated ed having more episodes of and anxiety. #73's active care plan, last uded the following focus s or has the potential to 	F 758					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345277	B. WING			C 09/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBOR	RO REHABILITATION AN	D HEALTHCARE CENTER					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 758	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	758			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED	
		(X1) PROVIDER/SUPPLIER/CLIA (X			E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345277	B. WING			C 09/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ASHEBOR	RO REHABILITATION AN	D HEALTHCARE CENTER			400 VISION DRIVE ASHEBORO, NC 27203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD BE G CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 758	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	758				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345277	B. WING			C 09/06/2024	
NAME OF PROVIDER	R OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
ASHEBORO REH	ABILITATION AN	D HEALTHCARE CENTER	400 VISION DRIVE ASHEBORO, NC 27203				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
revise exhibit mood and a plann 2/21/2 psych (antid includ (AIMS monit monit function indica medic and la the Pl Revie review 9/3/22 target an an A revi progra #68 h includ can la the Pl A revi Pl Revie review 9/3/22 target an an A revi Pl Revie	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	758			

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		ID HUMAN SERVICES				FORM	APPROVED	
							0.0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
			A. BOILDI			с		
		345277	B. WING			09/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
ACUEDO		D HEALTHCARE CENTER		40	0 VISION DRIVE			
ASHEBUR	CORENABILITATION AN	D REALINCARE CENTER		A	SHEBORO, NC 27203			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE	
					DEFICIENCY)			
F 758	Continued From page	e 28	F	758				
		esident #68's antipsychotic						
	and antidepressant m	nedications.						

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