DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES						APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(OMB NC	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(X3) DATE COMF	SURVEY PLETED
		345386	B. WING				04/	23/2025
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE			
	EGIONAL MEDICAL CTI				1370 WEST D STREET			
WILKESK	EGIONAL MEDICAL CTI	K SN			NORTH WILKESBORO, NC 28659			
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE		(X5) COMPLETION DATE
E 001 SS=F	CFR(s): 483.73	Emergency Program (EP)	E	001	1			5/22/25
		418.113, §441.184, §460.84, 83.475, §484.102, §485.68, §485.727, §485.920,						
	The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:							
	limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)							
	comply with all applic local emergency prep The hospital must der comprehensive emer- program that meets th section, utilizing an all emergency prepared but not be limited to,	gency preparedness he requirements of this Il-hazards approach. The ness program must include, the following elements:						
LABORATORY	with all applicable Fee emergency prepared	25:] The CAH must comply deral, State, and local ness requirements. The supplier representative's signature			TITLE			(X6) DATE

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.

05/16/2025

PRINTED: 05/23/2025

		ID HUMAN SERVICES MEDICAID SERVICES					RM APPROVE IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		E SURVEY IPLETED
		345386	B. WING			04	4/23/2025
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILKES F	REGIONAL MEDICAL CT	R SN			370 WEST D STREET IORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 001	emergency prepared but not be limited to, This REQUIREMENT by: Based on record rev facility failed to estab comprehensive Emer plan. The EP plan di Program patient popu information for staff, I long-term care (LTC) emergency officials of emergency officials of emergency prep train health systems. This all 8 residents and sta The findings included A review of the facility Preparedness (EP) p Management Manage in February 2025. Th present, updated, or a. The facility's EP pl program patient popu b. The facility's EP pl and contact informati physicians, other LTC c. The facility's EP pl emergency officials of Federal, State, tribal,	and maintain a gency preparedness all-hazards approach. The ness program must include, the following elements: - is not met as evidenced iew and staff interviews the lish and maintain a rgency Preparedness (EP) d not include the EP ulation, names and contact resident's physicians, other facilities, and volunteers, ontact information, ing program, and integrated a had the potential to affect aff. : /'s supplied Emergency lan revealed the Emergency er had reviewed the material he following areas were not revised: an did not include EP llation. an did not include names on for staff, resident C facilities, and volunteers.	E	001	Emergency Management (EM) has conducted a full crosswalk of all Long-Term Care (LTC) Emergency Preparedness (EP) requirements for t SNF and is addressing all areas. Completed 5/14/25 1) This crosswalk consists of review all policies and procedures to ensure t match expectations from both a regula perspective as well as meeting the ne of the SNF population. 2) Establishes a unified command w integrating into the hospitals overarch Incident Command System (ICS). 3) A standalone Emergency Management Binder has been built specific to the SNF and will remain present within the unit continuously wi staff education on intent and usage. 4) Education for SNF staff regarding Emergency Management Binder will b completed via written and inservice education by 5/21/25. Education ensu- staff knowledge of binder location, inte and purpose. 5) Target compliance date 5/22/25 Patient Population Action: Emergency Management and	ing they atory eds when ing th the ured ent,	
E 001	CAH must develop at comprehensive emer program, utilizing an emergency prepared but not be limited to, This REQUIREMENT by: Based on record rev facility failed to estab comprehensive Emer plan. The EP plan di Program patient popu information for staff, I long-term care (LTC) emergency officials c emergency prep train health systems. This all 8 residents and st The findings included A review of the facility Preparedness (EP) p Management Manag in February 2025. Th present, updated, or a. The facility's EP pl program patient popu b. The facility's EP pl and contact informati physicians, other LTC c. The facility's EP pl emergency officials c	and maintain a gency preparedness all-hazards approach. The ness program must include, the following elements: is not met as evidenced iew and staff interviews the lish and maintain a gency Preparedness (EP) d not include the EP ulation, names and contact resident's physicians, other facilities, and volunteers, ontact information, ing program, and integrated a had the potential to affect aff. : y's supplied Emergency lan revealed the Emergency er had reviewed the material the following areas were not revised: an did not include EP ulation. an did not include names on for staff, resident C facilities, and volunteers. an did not include ontact information including	E	001	 conducted a full crosswalk of all Long-Term Care (LTC) Emergency Preparedness (EP) requirements for t SNF and is addressing all areas. Completed 5/14/25 1) This crosswalk consists of review all policies and procedures to ensure t match expectations from both a regula perspective as well as meeting the ne of the SNF population. 2) Establishes a unified command w integrating into the hospitals overarch Incident Command System (ICS). 3) A standalone Emergency Management Binder has been built specific to the SNF and will remain present within the unit continuously wis staff education on intent and usage. 4) Education for SNF staff regarding Emergency Management Binder will b completed via written and inservice education by 5/21/25. Education ensu- staff knowledge of binder location, inte- and purpose. 5) Target compliance date 5/22/25 	ing they atory eds then ing th the ured ent, SNF	

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CENTER	5 FOR MEDICARE &	MEDICAID SERVICES				O. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345386	B. WING		04	4/23/2025
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
E 001	Continued From page	2	E 00	1		
	 Continued From page 2 d. The facility's EP plan did not include emergency prep training including initial training in emergency preparedness policies and procedures for all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. e. The facility's EP plan did not include integrated health systems 			its resident population to dete specific needs during an acti Emergency Operations Plan consists of clinical and other needs and associating each categories identified through Vulnerability Assessment (HV measure has been complete 8, 2025. An annual review w for ongoing compliance.	vation of the (EOP). This support within the risk our Hazard VA) This d as of May	
	reported he had revie February 2025. The Manager verified the patient/client populati to, persons at-risk; th facility could provide continuity of operation authority and success employment in Octob as Emergency Managen facility's EP plan did n contact information for physicians, other LTC The Emergency Mana confirmed the facility' emergency officials c Federal, State, tribal, preparedness staff.	er on 4/23/25 at 11:45am he ewed the current EP plan in Emergency Management facility had not addressed on, including, but not limited e type of services the LTC in an emergency; and ns, including delegations of sion plans prior to his per of 2024 nor after his start gement Manager. The nent Manager confirmed the not include names and or staff, resident's C facilities, and volunteers. agement Manager s EP plan did not include ontact information including regional, or local emergency The Emergency er verified the facility's EP		Communication (List of Staff other LTC facilities, Voluntee Action: SNF leadership has p Emergency Management wit staff and physicians assigned including mobile phone numb volunteers do not operate at Likewise, Emergency Manag developed a list of nearby LT and included within the Emer Management Binder. To enh response framework, this con directory has been added to Emergency Notification Syste allowing for mass messaging of the SNF during an emerge activation. This directory will by EM annually or more freq changes are identified. This is been completed as of May 8 Emergency Officials Contact	rs) provided h a list of all d to the unit pers (note: this location). mement has C facilities rgency ance our mmunication our em (ENS) to members ency be updated uently as measure has , 2025.	
	including initial trainin preparedness policies and existing staff, ind	mergency prep training ig in emergency s and procedures for all new ividuals providing services and volunteers, consistent		Action: Emergency Manager developed a comprehensive regional, State, and Federal information and included with Binder. This includes redund	list of local, contact nin the EM	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345386 B. WING 04/23/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1370 WEST D STREET WILKES REGIONAL MEDICAL CTR SN NORTH WILKESBORO, NC 28659 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 001 Continued From page 3 E 001 Management Manager confirmed that the but not limited to: Wilkes County facility's EP plan did not include integrated health Emergency Medical Services (EMS), systems. The Emergency Management Manager Wilkes County EM, Wilkes County Health stated he would be the person responsible for Department, North Carolina Emergency updating the EP plan information. The Management (24-Hour Watch Center), Emergency Management Manager stated that he NC EM Western Branch Office, NC was unaware that the skilled facility within the Department of Public Safety, Division of hospital system had it's own requirements of Health Services Regulation (DHSR), NC information that should be included in the Office of EMS (OEMS), Federal emergency preparedness plan but going forward Emergency Management Agency (FEMA) (24-Hour Watch Center), FEMA Region 4 he would certainly include the information. including State Administrator contact, During an interview with Nursing Assistant (NA) # amongst other support agencies. This 1 on 4/23/25 at 1:51pm she reported that EP measure has been completed as of May manual was probably in the Minimum Data Set 9, 2025. office. NA #1 reported that if there were an emergency she would first contact the nursing **Training Program** supervisor and then notify security. Action: Atrium Health Wake Forest Baptist (AHWFB) requires that all employees During an interview with Nurse # 3 on 4/23/25 at upon orientation (new hire) and on a 1:53pm she reported she was not sure where the continuous basis (annually) to complete EP manual was but assumed it was probably in Annual Required Learning (ARL) modules the nursing office. Nurse #3 pointed out the EP which include a portion specific to plan/diagram posted on the wall in hallway. emergency response policies and Nurse #3 stated if there was an emergency she procedures. These training courses are would first contact the staff in the office who are updated yearly based on HVA results and in charge and if it were a weekend she would call include a testing component that all the nursing supervisor. teammates, volunteers, and contractors must successfully pass to demonstrate During an interview with the Doctor of Nursing competency. This measure has been Practice (DNP) on 4/23/25 at 2:14pm she completed as of May 9, 2025. An annual reported never seeing the EP checklist and was review will be done for ongoing not aware of the information or training that was compliance. required for the facility unit. The DNP reported she understood what needed to change. Integrated Health System Action: Emergency Management maintains an Emergency Management Plan (EMP) that aligns the Emergency Program from a market perspective

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

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/23/2 FORM APPRO OMB NO. 0938-0
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345386	B. WING		04/23/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	EGIONAL MEDICAL CT			1370 WEST D STREET	
WILKES K	EGIONAL MEDICAL CT	X SIN		NORTH WILKESBORO, NC 28659	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLET
E 001 F 000	Continued From page		E 00 F 00	(Wake Market/Winston-Salem) integration from an enterprise a (Atrium Health/Advocate). This EMP has been active since 202 establishes a response framew include both acute care and no care settings, including LTC, Ar and other service lines. A copy has been included within the EI and is available for review as n This measure, including submis the EM binder, has been compl May 8, 2025. An annual review done for ongoing compliance.	approach Integrated 23 and vork to n-acute mbulatory, of the EMP M Binder ecessary. ssion within leted as of
	conducted from 4/21/ ID# UH8N11.	ertification survey was 25 through 4/23/25. Event			
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g)	ents	F 64	1	5/22/25
	resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) asse oxygen for 1 of 8 resi whose MDS assessm The findings included Resident #109 was a 4/3/2025 with diagnos	t accurately reflect the is not met as evidenced iew and staff interviews, the ately code the Minimum ssment for the use of dents (Resident #109) nents were reviewed. : dmitted to the facility on sis that included chronic		Corrective Action for Affected F The affected resident oxygen o (resident 109) was immediately Oxygen therapy was initiated a on 4/19/25. MDS coordinator in reviewed the MDS and found o not been placed during the MD observation period.	rder / reviewed. s ordered nmediately xygen had S s at Risk: A
	obstructive pulmonar	y disease (COPD).		screen of all residents was com	ipleted on

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	S FOR MEDICARE &				OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345386	B. WING		04/23/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē
WILKES F	REGIONAL MEDICAL CT	'R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 641	(MDS) dated 4/12/20 was cognitively intact diagnosis of COPD a oxygen use. A review of Resident oxygen care orders: - (4/8/25) Nasal Canto oxygen saturation gro- - (4/8/25) Pulse oxim oxygen saturations g An interview with the 4/23/25 at 10:43 AM should be addressed them in assessments	ssion Minimum Data Set 025 revealed Resident #109 t. The MDS indicated and was not coded for t #109's orders revealed nula 1 liter per minute, keep eater than 92% uetry, continuous, maintain	F 64	 all residents on 4/23/25 to ass therapy orders and correct init no discrepancies found. Systemic Changes to Prevent Recurrence: New Order Process revised to 1. Mandatory nursing review oxygen therapy orders for corri implementation effective by 5/ 2. Initial review conducted b to be followed by Charge Nursidesignee within 24hrs effective 5/21/25. Nursing Staff re-education inc 1. Importance of timely revie correct implementation of all of therapy orders 2. Correct Documentation of therapy in the Medical Record care 3. Including Oxygen therapy communications such as shift 4. Educational components incorporated into new staff or plan 5. Nursing Education will be by 5/21/25. Monitoring and Quality Assura Charge Nurse or a designee to 1. As of 5/21/25, review eve Resident O2 order for correct implementation and documentation 2. As of 5/21/25 100% review oxygen therapy orders and MI will be conducted for the next 	tiation with include: y of all rect (21/25 y Staff nurse se or e by luding: ew and bxygen f Oxygen and plan of y status in handoff. have been entation completed ance oo: ry new tation daily. ew of all new DS Coding

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/23/202 MAPPROVE D. 0938-039
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY
		345386	B. WING			04/23/2025	
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
	REGIONAL MEDICAL CT	R SN			70 WEST D STREET DRTH WILKESBORO, NC 28659		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 641	Continued From page	e 6	F 6	41	 compliance. 3. Results will be reviewed monthly both nurse manager and charge nurse and at each QAA meeting. 4. Any trends or recurrent issues wil prompt immediate re-education and process review. 	es	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)	-(3)	F 6	55	Target Full Compliance Date: 5/22/25		5/22/25
	Planning §483.21(a) Baseline (§483.21(a)(1) The fac implement a baseline that includes the instr effective and person- that meet professiona The baseline care pla (i) Be developed with admission. (ii) Include the minim necessary to properly including, but not limi (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomm §483.21(a)(2) The fac comprehensive care care plan if the comp	cility must develop and e care plan for each resident ructions needed to provide centered care of the resident al standards of quality care. an must- in 48 hours of a resident's um healthcare information y care for a resident ted to- d on admission orders.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345386 B. WING 04/23/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1370 WEST D STREET WILKES REGIONAL MEDICAL CTR SN NORTH WILKESBORO, NC 28659 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 655 Continued From page 7 F 655 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the Corrective Action for Affected Residents: facility failed to develop a baseline care plan that 1. The residents oxygen and respiratory addressed a resident's oxygen and respiratory care needs were immediately assessed care for 2 of 3 residents reviewed for baseline by the RN on 4/22/25. care plans (Resident #109 and Resident #110). 2. A baseline care plan was created and implemented to address oxygen therapy The findings included: and respiratory care by the RN on 4/22/25. For Resident 109 care plan 1. Resident #109 was admitted to the facility on additions included Chronic Disease 4/3/2025 and readmitted on 4/8/25 with a Management and Alternate Respiratory diagnosis that included chronic obstructive Status. For Resident 110 an Altered pulmonary disease (COPD). Respiratory Status care plan was added. A review of the admission Minimum Data Set Identification of Other Residents at Risk: A (MDS) dated 4/12/2025 revealed Resident #109 screen of all residents was completed by was cognitively intact. The MDS also indicated the RN on 4/22/25 to assess oxygen and diagnosis of Chronic Obstructive Pulmonary respiratory care plan needs with no Disease (COPD) and was not coded for oxygen. discrepancies found. A review of Resident #109's active care plan Systemic Changes to Prevent dated 4/8/2025 revealed there were no goals or Recurrence:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345386 B. WING 04/23/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1370 WEST D STREET WILKES REGIONAL MEDICAL CTR SN NORTH WILKESBORO, NC 28659 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 655 Continued From page 8 F 655 interventions regarding oxygen or respiratory care **Baseline Care plan Implementation** included in the baseline care plan. Process revised to include within 48hrs of admission or with any new oxygen or An interview with Nurse #1 on 04/22/25 at 01:22 respiratory care needs: PM stated orders and care plans were reviewed 1. Mandatory Staff RN review of all by the nurse each shift. Nurse #1 confirmed identified patients with oxygen and Resident #109 was receiving oxygen and respiratory care needs for timely baseline respiratory status was assessed. Nurse #1 care plan implementation effective stated that respiratory care was not added to the 5/21/25 care plan when Resident #109 was readmitted to 2. A daily review by Charge Nurse or designee within 24hrs effective 5/21/25. the unit. Nurse #1 reported oxygen and oxygen monitoring was ordered on readmission. Nursing Staff re-education includes: A review of Resident #109's orders revealed 1. Importance of timely implementation oxygen care orders: within 48hrs of admission, or upon a - (4/8/25) Nasal Cannula 1 liter per minute, keep change in a residents respiratory status oxygen saturation greater than 92% an individualized baseline care plan - (4/8/25) Pulse oximetry, continuous, maintain 2. Nursing Education will be completed oxygen saturations greater than 94% by 5/21/25. 3. Nursing Education will be An interview with the MDS Coordinator on incorporated into a new staff orientation 4/23/25 at 10:43 AM revealed respiratory orders plan. should be added to the care plan and resolved on discharged. The MDS Coordinator reported the Monitoring and Quality Assurance (How nurse should address respiratory care in the care often and who) plan on admission and any time after if not Charge Nurse or a designee too: addressed on admission. 1. As of 5/21/25, conduct 100% review of residents with identified Oxygen or An interview with the Nurse Manager on 4/23/25 respiratory care needs for correct baseline at 1:47 PM revealed that each nurse was care plan initiation. expected to review orders and the care plan for 2. As of 5/21/25 conduct 100% review of oxygen needs and to communicate any changes all new admissions or residents with during the shift change report. The Nurse condition change with oxygen or Manager stated that nurses should add respiratory care needs for correct baseline care plan initiation for the next 60 days respiratory care to the care plan upon admission. She also stated that nurses should have with random reviews thereafter to ensure addressed respiratory care in the care plan for ongoing compliance. Resident #109 when reviewing the care plan 3 Results will be reviewed monthly by during the shift. both nurse manager and charge nurses

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					OMB NO. 0938-0		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345386	B. WING		04/23/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILKES F	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659			
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLE		
F 655	Continued From page	e 9	F 65	5			
		s admitted to the facility on tted on 4/14/2025 with ed respiratory failure.		 and at each QAA meeting. 4. Any trends or recurrent issuprompt immediate re-education a process review. 			
	Data Set (MDS) date diagnosis of chronic i hypoxia and was cod	#110's quarterly Minimum d 2/28/2025 indicated respiratory failure with led for oxygen use. The MDS ent #110 was cognitively		Target Full Compliance Date: 5/2	22/25		
	dated 4/8/2025 revea	#110's active care plan aled there were no goals or ng oxygen or respiratory care ine care plan.					
	An interview with Nurse #1 on /22/25 at 01:22 PM stated orders and care plans were reviewed by the nurse each shift. Nurse #1 confirmed Resident #110 was receiving oxygen and respiratory status was assessed. Nurse #1 stated that respiratory care was not added to the care plan when Resident #110 was readmitted to the unit. Nurse #1 reported oxygen and oxygen monitoring was ordered on readmission.						
	revealed: -(4/14/25) Oxygen Th liters per minute, kee greater than 90%. -(4/14/25) Initiate Adu Chronic-Stable Bileve Continuous Positive A	el Positive Airway Pressure/ Airway Pressure col (Adult Non-invasive					

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ATC					OMB NO. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345386	B. WING		04/23/2025	
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VILKES F	REGIONAL MEDICAL CTI	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC	
F 655	Continued From page	e 10	F 6	55		
	4/23/25 at 10:43 AM	revealed respiratory orders				
	should be added to the care plan and resolved on					
		S Coordinator reported the				
		respiratory care in the care d any time after if not				
	addressed on admiss	-				
	An interview with the at 1:47 PM revealed t	Nurse Manager on 04/23/25				
		ders and the care plan for				
		communicate any changes				
	during the shift chang	-				
	Manager stated that r					
	She also stated that r	e care plan upon admission. Surses should have				
		/ care in the care plan for				
		reviewing the care plan				
	during the shift.					
F 658 SS=D	Services Provided Me CFR(s): 483.21(b)(3)	eet Professional Standards (i)	F 65	58	5/22/25	
	§483.21(b)(3) Compr					
		d or arranged by the facility, nprehensive care plan,				
	must-	חייים איז				
	(i) Meet professional This REQUIREMENT	standards of quality. is not met as evidenced				
	by:	na manual productions of the fit				
		ns, record review and staff failed to follow physician		Corrective Action for Affected Reside 1. The resident was assessed for p		
	orders for 1 of 1 resid			positioning of the affected lower extre		
		onal standards of practice.		and offloading boot applied by the RN 4/22/25.	-	
	The findings included	:		 SNF staff performed routine roun on 4/22/25 and ongoing to evaluate 	lding	
	Resident #209 was a	dmitted to the facility on		appropriate offloading of affected low	er	
	4/18/2025 with a diag	nosis that included		extremity.		
	Diabetes, and bilatera	al lea swelling				

Event ID: UH8N11

Facility ID: 943561

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			0.00			0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		345386	B. WING		04/2	3/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		5/2020
				1370 WEST D STREET		
NILKES F	EGIONAL MEDICAL CT	R SN		NORTH WILKESBORO, NC 2	8659	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG			
F 658	Continued From page	e 11	F 6	58		
		5		Identification of Other Re	esidents at Risk [.] A	
	A review of the Admis	ssion Statement submitted		screen of all residents w		
		2025 revealed Resident		4/22/25 by Staff RN to a	-	
	-	iented to place, time, person,		of ordered pressure relie	•	
		as clear, and cognition level		or devices with no non-c		
		ttention/concentration. At				
	the time of review no			Systemic Changes to Pr	revent	
	identified.			Recurrence:		
				Nursing and Therapy St	aff re-education	
	A review of the physic	cian orders dated 4/18/25		includes:		
		for no-sting barrier film to		1. Importance of adhe	rence to provider	
	the right heel, heel flo	pating boot placed on		order for pressure reliev	ing interventions	
	resident, and float he	els always.		or devices	-	
				2. Proper monitoring t	hroughout shift of	
	A review of the Basel	ine Care Plan dated		continued compliance w	ith ordered	
	04/18/2025 revealed a problem as skin integrity.			offloading		
	The goal listed was the	hat skin integrity would		4. Proper communicat	ion of pressure	
		rventions of providing skin		relieving treatments or d	evices during	
	care and provide pres	ssure relieving interventions.		handoff.		
				5. Nursing and Therap	-	
	An observation and in	nterview on 4/21/2025 at		will be completed by 5/2	1/25.	
		sident #209 was up in a		6. Nursing Education		
		t elevated with no heel		incorporated into new st	aff orientation	
		sident #209's heels were not		plan.		
		09 stated he was admitted				
		e swollen. He stated he was		Monitoring and Quality A		
	doing exercises with	•		Charge Nurse or a desig		
		al Therapy (PT/OT) to get rid		1. As of 5/21/25 condu	2	
	of the fluid in his legs			review of all residents w		
	Observation at 1/21/	25 at 3:15 PM revealed		pressure-relieving interv to ensure implementatio		
		bed with a heel floating		for the next 60 days. Re		
		There was no heal floating		completed utilizing routi		
	-	t the time of the observation.		random reviews thereaft	-	
		he had a heel floating boot		ongoing compliance.		
		bed. Resident #209 stated		2. Results will be revie	wed monthly by	
	-	e chair staff removed his heel		both nurse manager and		
		ould get some traction.		and at each QAA meetin	-	
		I they leave the heal floating		3. Any trends or recur		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURV		
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
		345386	B. WING		04/23/20	025	
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
WILKES F	REGIONAL MEDICAL CTI	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CON	(X5) MPLETIO DATE	
F 658	Continued From page	e 12	F 658				
	boot off while he was			prompt immediate re-educatio process review.	n and		
	An observation and interview with the Occupational Therapist on 4/22/2025 at 10:41AM revealed Resident #209 lying in the bed with both legs laying flat on the bed without a heel floating boot on the right foot. Two pillows were observed to the right of Resident #209's legs. A dark purple circular area was observed on the resident's right heal. At the end of therapy Resident #209 was assisted into the recliner by the therapist with the stand to lift chair. She was observed floating the residents heals with two pillows under his legs but did not place the heel floating boot on Resident #209's right heel. The therapist stated she assisted him in the chair for the first time on 4/21/2025.			Target Full Compliance Date:	5/22/25		
	4/22/2025 at 12:21 Pl nurse that admitted R 4/18/2025. She stated right leg that looked li and a light gray area read the treatment or interview. Orders for right heel daily, heal f patient, and float hea she received a new h morning around 10:30 was dirty, but she did Nurse #1 and the sur #209's room. The res recliner with both hee without his heels bein	ervation with Nurse #1 on M revealed she was the Resident #209 on the d he had dry areas to his ike scratches and abrasions on his right heel. Nurse #1 ders out loud during the no sting barrier film to the floating boot placed on ls at all times. She stated eal floating boot for him this Dam because the other one not have time to apply it yet. veyor walked to Resident sident was sitting in the els resting on the leg rest ng floated. Nurse #1 placed on the right foot. Nurse #1					

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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	
		345386	B. WING			04/	23/2025
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
WILKES R	EGIONAL MEDICAL CT	RSN			370 WEST D STREET IORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 658	(MDS)/Nurse Supervi revealed that a new h in for him today becau The MDS/Nurse Super Resident #209 had be heel floating boot or for The MDS/Nurse Sper boot was not available heels to be floated. An interview with Nurse PM revealed she had Resident #209's legs she removed pillows a tray on the overbed ta She stated she thoug back under Resident forgotten. Nurse #6 st	sor on 4/22/25 at 12:33pm weel floating boot had come use the old one was soiled. ervisor was made aware that een observed without the eet being floated on pillows. rvisor stated if a heel floating e, she would expect the se #6 on 4/22/2025 at 1:03 removed the pillows under during lunch. She stated so she could place his lunch able over the resident's lap. ht she had put the pillows #209's legs but must have tated if the heel floating boot the resident she would float	F	6558			
F 695 SS=D	04/22/25 at 2:03 PM m assessed Resident #2 was notified that Resi without a heel floating without his heels bein would expect staff to floating boot and heel Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care an The facility must ensu- needs respiratory care	209 this morning. The PA dent #209 was observed g boot on his right foot and ig floated. He stated he follow the orders for the heel is to be floated. tomy Care and Suctioning	F	695			5/22/25

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		MEDICAID SERVICES				OMB NO	M APPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
		345386	B. WING _			04/23/2025	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	REGIONAL MEDICAL CT	D CN		13	70 WEST D STREET		
WILKES P				NC	ORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 695	Continued From page	e 14	F6	695			
	practice, the comprel care plan, the resider	nensive person-centered nts' goals and preferences,					
	and 483.65 of this su This REQUIREMENT by:	bpart. Γ is not met as evidenced					
	Based on observations, record review, and staff interviews, the facility failed to post cautionary				Corrective Action for Affected Resider On 4/21/25 an immediate signage was		
		utside resident rooms that			posted on the affected residents' door		
		oxygen and failed to follow			residents 109 and 110 with clear visibi		
	-	ated to oxygen use for 2 of 2			by public traffic indicating Oxygen in U	se.	
	#109, and Resident #	or respiratory care (Resident			The affected resident oxygen order (resident 109) was immediately review	hav	
		<i>i</i> 110 <i>)</i> .			Oxygen therapy was initiated as order		
	The findings included	l:			on 4/19/25. MDS coordinator immedia reviewed the MDS and found oxygen I	tely	
	A. Resident #109 wa	s admitted to the facility on			not been placed during the MDS		
		sis that included chronic			observation period. Detailed plan of		
	obstructive pulmonar				correction for oxygen discrepancy is outlined in F641.		
		ssion Minimum Data Set					
		25 revealed Resident #109			Identification of Other Residents at Ris	sk: A	
	was cognitively intact				screen of all resident doors was completed on 4/21/25 by the staff RN	ta	
	oxygen use.	nd was not coded for			assess oxygen signage needs with no further discrepancies found.		
	A review of Resident	#109's active care plan					
	dated 4/8/2025 revea	aled there were no goals or			Systemic Changes to Prevent		
		ng oxygen or respiratory care			Recurrence:		
	included in the baseli	•			In addition to Oxygen in Use signage		
		2025 oxygen assessment			displayed over entry to facility, addition	nal	
		revealed all nursing staff flow rate was 2 liters per			Oxygen in Use signage has been		
		d a spot check for oxygen			obtained for display on all entry room doors for impacted residents.		
					Nursing Staff re-education includes:		
	A review of Resident	#109's orders revealed			1. On 4/21/25 verbal communication	I	
	oxygen care orders:				regarding the posting of the Oxygen in	I	
		nula 1 liter per minute, keep			use sign on impacted residents entry		
	oxygen saturation gre	eater than 92%			room doors was completed with onsite		

Facility ID: 943561

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345386 B. WING 04/23/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1370 WEST D STREET WILKES REGIONAL MEDICAL CTR SN NORTH WILKESBORO, NC 28659 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 695 Continued From page 15 F 695 - (4/8/25) Pulse oximetry, continuous, maintain nursing staff. oxygen saturations greater than 94% 2. Further education regarding the Oxygen in Use signage on resident room An observation on 04/21/25 at 11:01 AM revealed entry doors with all nursing staff will be Resident #109 sitting in his wheelchair with completed by 5/21/25. oxvgen being administered via nasal cannula via 3. Nursing Education will be wall oxygen concentrator at 2 liters. There was incorporated into new staff orientation no caution or safety signage posted outside of plan. Resident #109's room indicating supplemental oxygen was in use. Monitoring and Quality Assurance Charge Nurse or a designee too: An observation on 04/22/25 at 9:25 AM revealed 1. As of 5/21/25 conduct 100% daily Resident #109 sleeping in bed with oxygen being review of all resident doorways with administered via nasal cannula via wall oxygen oxygen in use to ensure appropriate concentrator 2 liters. There was no caution or signage for the next 60 days with random safety signage posted outside of Resident #109's reviews thereafter to ensure ongoing room indicating supplemental oxygen was in use. compliance. 2. Results will be reviewed monthly by B. Resident #110 was originally admitted to the both nurse manager and charge nurses facility on 9/3/2021 and readmitted on 4/14/2025 and at each QAA meeting. 3. Any trends or recurrent issues will with diagnosis that included respiratory failure. prompt immediate re-education and A review of the quarterly Minimum Data Set process review. (MDS) dated 2/28/2025 indicated diagnosis of chronic respiratory failure with hypoxia and was Target Full Compliance Date: 5/22/25 coded for oxygen use. A review of Resident #110's oxygen care orders revealed: -(4/14/25) Oxygen Therapy nasal cannula, rate 3 liters per minute, keep oxygen saturation level greater than 90%. -(4/14/25) Initiate Adult Respiratory Chronic-Stable Bilevel Positive Airway Pressure/ Continuous Positive Airway Pressure (BIPAP/CPAP) Protocol (Adult Non-invasive Ventilation) continuously. An observation on 4/21/25 at 12:39 PM revealed

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

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 0 FORM AF OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	-	(X3) DATE SUR COMPLETE	RVEY
		345386	B. WING			04/23/2	2025
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
WILKES F	REGIONAL MEDICAL CT	RSN		1370 WEST D STREET NORTH WILKESBORO	, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) DMPLETION DATE
F 695	Resident #110 awake with oxygen being ad via wall oxygen conce caution or safety sign Resident #110's room oxygen in use. Resid enough observation on 4/2 Resident #110 asleep administered via BIP/ concentrator. There signage posted outsid indicating supplemen An observation of sig the entrance of the sk at 11:00 AM and 4/23 Smoking Oxygen in U An interview with Nur PM stated she did no signs were on the res aware oxygen caution resident doors. Nurse was communicated vor residents had oxygen by the nurse each shift. An interview with Nur stated there was an of the entrance doors to Smoking Oxygen in U she had worked for the and used to place oxy resident doors. Nurse	e with head of bed elevated ministered via nasal cannula entrator. There was no age posted outside of n indicating supplemental lent did not allow a close o view liters of oxygen 23/25 at 2:51 PM revealed o with oxygen being AP via wall oxygen was no caution or safety de of Resident #109's room tal oxygen was in use. Ins above double doors to killed nursing unit on 4/21/25 5/25 at 8:30 AM, stated "No Jse." se #1 on 4/22/25 at 01:22 t know if oxygen caution sident's door, and was not n sign should be posted on e #1 reported oxygen use erbally to other staff if n, and orders were reviewed iff. Nurse #1 also stated a ent was completed by each se #2 on 4/22/25 at 1:30 PM oxygen cautionary sign over the unit that stated, "No Jse." Nurse #2 reported that he facility for seven years	F 69	5			

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	S FOR MEDICARE &				OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345386	B. WING		04/23/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VILKES R	EGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659	
(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 APP! DEFICIENCY)	ULD BE COMPLET
F 695	Continued From page	e 17	F 69	95	
		ers were communicated in			
	-	luring each shift change. oxygen levels and care were			
		g nurse-to-nurse shift report.			
		Numer Manager en 4/00/05			
	An interview with the Nurse Manager on 4/23/25 at 1:47 PM reported oxygen caution signs were				
	-	uble doors to the entrance of			
		ents' doors. Nurse Manager			
		gns should be placed when ented. Nurse Manager			
	revealed a respirator	-			
		ed in the electronic health			
	record. The assessment of oxyge	nent included an en administration level. She			
		irse would review orders and			
	a care plan for oxyge	n needs and communicate			
		shift change report. If there			
		what the nurse assessed the nurse would call the			
		cure chat to clarify an order.			
		eported the nurses missed			
F 756	clarifying the order fo	w, Report Irregular, Act On	F 75	56	5/22/25
SS=D	CFR(s): 483.45(c)(1)		170		5/22/25
	§483.45(c) Drug Reg				
		ug regimen of each resident			
	licensed pharmacist.	least once a month by a			
	§483.45(c)(2) This re of the resident's med	view must include a review ical chart.			
		armacist must report any			
	irregularities to the at	armacist must report any tending physician and the ctor and director of nursing,			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/23/20 FORM APPROVE OMB NO. 0938-03
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345386	B. WING		04/23/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•
	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28	8659
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
F 756	drug that meets the c (d) of this section for (ii) Any irregularities of during this review mu separate, written repo- attending physician a director and director of minimum, the resider and the irregularity th (iii) The attending phy resident's medical red irregularity has been action has been take be no change in the r physician should doc the resident's medical §483.45(c)(5) The fac maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent action This REQUIREMENT by: Based on record rev Pharmacist interview failed to communicate limit the use of a psyc affects the mental sta days for 1 of 5 reside unnecessary medical The findings included Resident #2 was adm	de, but are not limited to, any priteria set forth in paragraph an unnecessary drug. noted by the pharmacist ist be documented on a port that is sent to the and the facility's medical of nursing and lists, at a nt's name, the relevant drug, ie pharmacist identified. ysician must document in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in al record. cility must develop and procedures for the monthly that include, but are not is for the different steps in is the pharmacist must take ifies an irregularity that in to protect the resident. T is not met as evidenced iews and Consultant is, the Consultant Pharmacist ie to the facility the need to chotropic drug (drug that ate) ordered as needed to 14 ints reviewed for tions (Resident #2).	F	Corrective Actions: 1. Immediate action or Advanced Practice Provi face evaluation of patien medication (Ativan) was (complete 4/23/2025). 2. Immediate action Ec provided on 4/23 to prov Informacist associated w entered prn Ativan order centered on proper way medication stop date (en	ider did face to t to determine still needed ducation was ider by Clinical <i>v</i> ith improperly . Education to enter

Event ID: UH8N11

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345386	B. WING		04/23/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
WILKES F	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28	659
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE	CTION SHOULD BE COMPLETING COMPLETING COMPLETING COMPLETING COMPLETING DATE
F 756	Continued From page	e 19	F 75	6	
	(antianxiety) 0.5 millig daily as needed for a 12/12/2024 for a dura Review of January 20 #2 received Ativan 0. from 01/01/25 throug The Pharmacy Const dated 1/13/25 include stop date for Ativan 0 clinically significant m Review of February 2 #2 received Ativan 0. from 2/1/25 through 2 The Pharmacy Const dated 2/14/25 include stop date for Ativan 0	ultant's drug regimen review ed no recommendations for a 0.5 mg and there was no nedication issues identified. 2025 MAR revealed Resident 5 mg by mouth each night		 not to place this informati field (comment field). (co 4/23/2025). 3. Education was provid Director for all pharmacis pharmacy regulations (ce 14-day stop of psychotrop antipsychotic medications and in-person 5/14). The with pharmacist at WMC pm (complete 4/23/2025 4. Education for provid Pharmacy Director is sch to enhance education and around pharmacy recomment state pharmacy requirer home patients (focus on po of psychotropic and antip medications), (scheduled 5. As of 5/12/25 current process to receive daily a reports for psychotropic and medications. (Initiation p 	ided by Pharmacy t on SNF entered on prn pic and s) by email on 5/9 in-person review was on 5/14 at 2 b). lers by the eduled for 5/21 d knowledge mendations and ments for nursing prn 14 day stop sychotic for 5/21/2025). tly working on a automated and antipsychotic
	#2 received Ativan 0. from 3/1/25 through 3 The Pharmacy Const dated 3/12/25 include stop date for Ativan 0 clinically significant m The Quarterly Minimu 3/18/25 revealed Res intact. The MDS docu	ultant's drug regimen review ed no recommendations for a 0.5 mg and there was no nedication issues identified. um Data Set (MDS) dated sident #2 was cognitively umented Resident #2 medication 7 out of 7 days		 Preventing Future Occurr 1. Education provided & Director to providers and (complete by 5/21), and v incorporated into orientation Pharmacist. 2. Pharmacy will monitor regiment irregularities three process of patient initial of 7 day review on new SNF monthly 30 day review at patients. Pharmacy will p documentation of any irree Encompass (electronic m 	by Pharmacy pharmacists will be ion of new or for any drug ough our current order reviews, a F patients and our WMC on all provide written egularities in

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
		345386	B. WING		04/23/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
WILKES F	REGIONAL MEDICAL CT	R SN		370 WEST D STREET ORTH WILKESBORO, NC 28659	
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI
F 756	Continued From page	e 20	F 756		
F 758 SS=D	During an interview w on 4/23/25 at 2:00 PM psychotropics should Pharmacy Consultan Resident #2's chart a had been entered inco have triggered the "sa was not realized until during this survey. S aware that all as need have a stop date and days. She stated this was missed because entered in a commen the actual order and y January 2025, Februa monthly pharmacy re order flowed over to to order without a stop of Free from Unnec Psy CFR(s): 483.45(c)(3) §483.45(e) Psychotro §483.45(e) Psychotro §483.45(c)(3) A psych affects brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic	with the Pharmacy Consultant M, she stated that as needed have a stop date. The t reported she reviewed and realized the original order correctly which would not afeguards". She reports this it was called to her attention he reported that she was ded psychotropics should be reviewed every 14-21 particular order stop date the "for 14 days" was it section that was not part of was not caught during the ary 2025, and March 2025 views. Therefore, when the the MAR it showed as an date. vchotropic Meds/PRN Use (e)(1)-(5) ppic Drugs. hotropic drug is any drug that associated with mental vior. These drugs include, drugs in the following	F 758	communication tool) to provider. A medication changes will be escalar direct provider call and final escala SNF program leaders. 3. Monitoring results will be repo through the SNF QAA Committee 4. Target Compliance date 5/22/	ted to a tion to rted

Facility ID: 943561

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	S FOR MEDICARE &				OMB NO. 09	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345386	B. WING		04/23/2	2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	EGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659		
(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 SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE CC	(X5) DMPLETIC DATE
F 758	1.0		F 75	58		
		n is necessary to treat a diagnosed and documented				
	drugs receive gradua behavioral interventio	nts who use psychotropic l dose reductions, and ns, unless clinically effort to discontinue these				
	unless that medicatio	ursuant to a PRN order n is necessary to treat a ndition that is documented				
	are limited to 14 days §483.45(e)(5), if the a prescribing practitione appropriate for the PF beyond 14 days, he o	er believes that it is RN order to be extended or she should document their ent's medical record and				
	drugs are limited to 1 renewed unless the a prescribing practitione the appropriateness of	ttending physician or er evaluates the resident for				
	Based on record revi Pharmacist, and Nurs the facility failed to co psychotropic (drug th medication order to in	ews, staff, Consultant se Practitioner interviews, irrectly enter an as needed at affects the mental state) include the 14 day stop date viewed for unnecessary		Corrective Actions: 1. Immediate action on 4/23/20 Advanced Practice Provider did f face evaluation of patient to deter medication (Ativan) was still neer (complete 4/23/2025). 2. Immediate action Education	face to rmine ded	

Facility ID: 943561

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345386 B. WING 04/23/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1370 WEST D STREET WILKES REGIONAL MEDICAL CTR SN NORTH WILKESBORO, NC 28659 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 758 Continued From page 22 F 758 provided on 4/23 to provider by Clinical The findings included: Informacist associated with improperly entered prn Ativan order. Education Resident #2 was admitted to the facility on centered on proper way to enter 12/11/24 with a diagnosis of anxiety disorder. medication stop date (end date field) and not to place this information in the prn The physician order dated 12/11/24 reviewed for field (comment field). (complete Resident #2 revealed an order for Ativan 4/23/2025). (antianxiety) 0.5 milligrams (mg) by mouth twice 3 Education was provided by Pharmacy daily as needed for anxiety with a start date of Director for all pharmacist on SNF 12/12/2024 for a duration of 14 days (12/26/24). pharmacy regulations (centered on prn 14-day stop of psychotropic and Review of the December 2024 Medication antipsychotic medications) by email on 5/9 Administration Record (MAR) revealed Resident and in-person 5/14). The in-person review #2 received Ativan 0.5 mg by mouth each night with pharmacist at WMC was on 5/14 at 2 from 12/11/24 through 12/27/24. He did not pm (complete 4/23/2025). receive it on 12/29/24. He did receive it on 4. Education for providers by the 12/30/24 and 12/31/24. Pharmacy Director is scheduled for 5/21 to enhance education and knowledge Review of January 2025 MAR revealed Resident around pharmacy recommendations and #2 received Ativan 0.5 mg by mouth each night state pharmacy requirements for nursing from 01/01/25 through 01/31/25. home patients (focus on prn 14 day stop of psychotropic and antipsychotic Review of February 2025 MAR revealed Resident medications), (scheduled for 5/21/2025). #2 received Ativan 0.5 mg by mouth each night 5. As of 5/12/25 currently working on a from 2/1/25 through 2/28/25. process to receive daily automated reports for psychotropic and antipsychotic Review of March 2025 MAR revealed Resident medications. (Initiation phase started). #2 received Ativan 0.5 mg by mouth each night from 3/1/25 through 3/31/25. Preventing Future Occurrences: 1. Education provided by Pharmacy The Quarterly Minimum Data Set (MDS) dated Director to providers and pharmacists 3/18/25 revealed Resident #2 was cognitively (complete by 5/21, and will be intact. The MDS documented Resident #2 incorporated into orientation of new received antianxiety medication 7 out of 7 days Pharmacist. during the assessment period. 2. Pharmacy will monitor for any drug regiment irregularities through our current Review of April 2025 MAR revealed Resident #2 process of patient initial order reviews, a received Ativan 0.5 mg by mouth each night from 7 day review on new SNF patients and our

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

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/23/2025 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345386	B. WING			04/	23/2025
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WILKES F	REGIONAL MEDICAL CTR	R SN			370 WEST D STREET IORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 758	1:10 PM, she stated t into their system, activiover, and she believe and what the provider receive. Nurse #4 ver 14 days" on the order was a continuous ord An interview with the 4/23/25 at 1:20 PM re Ativan should have have that she felt the order the hospitalist on adm She reported the "for 12/12/24 should have questioned. During an interview with 4/23/25 at 1:45 PM, s Ativan 0.5 mg twice d for 14 days had been hospitalist. The hosp 14 days" in the commincluded the end date explained by notating section this caused no alerts in the system to attention to the durative reported "it just slipped The Hospitalist that et 12/11/24 was not ava 4/23/25 at 1:15 PM During an interview with	5. ith Nurse #4 on 4/23/25 at hat when orders were put ve orders would transfer d those orders to be correct wanted the resident to balized she could view "for and reported she thought it er. Unit Nurse Manager on vealed that the order for ad a stop date. She reported was entered incorrectly by hission with no stop date. 14 days" with a start date of been noticed and ith the Nurse Practitioner on he stated the order for aily as needed for anxiety entered by one of the italist had entered the "for the 14 days in the comment one of the safeguards or o activate and no one paid on of the Ativan. She ed through the cracks".	F	758	monthly 30 day review at WMC on all patients. Pharmacy will provide writte documentation of any irregularities in Encompass (electronic medical record and through secure chat (Encompass communication tool) to provider. All ur medication changes will be escalated direct provider call and final escalation SNF program leaders. 3. Monitoring results will be reported through the SNF QAA Committee. 4. Target Compliance date 5/22/25	l) gent to a i to	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345386	B. WING		04/23/2025
ME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ILKES R	EGIONAL MEDICAL CT	R SN		370 WEST D STREET IORTH WILKESBORO, NC 28659	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC
F 758	Continued From page	24	F 758		
		have a stop date. The			
	Pharmacy Consultant reported she reviewed Resident #2's chart and realized the original order				
		orrectly which would not			
		afeguards". She reported			
	that she was aware the psychotropics should	hat all as needed have a stop date and be			
	reviewed every 14-21	-			
		ore/Prepare/Serve-Sanitary	F 812		5/16/25
SS=F	CFR(s): 483.60(i)(1)(2	2)			
	§483.60(i) Food safet The facility must -	y requirements.			
	§483.60(i)(1) - Procur				
	approved or consider state or local authoriti	ed satisfactory by federal,			
		ood items obtained directly			
	from local producers,	subject to applicable State			
	and local laws or regu				
		s not prohibit or prevent roduce grown in facility			
	gardens, subject to co	ompliance with applicable			
	safe growing and food	d-handling practices. es not preclude residents			
		s not procured by the facility.			
		prepare, distribute and			
	serve food in accorda standards for food se	•			
		is not met as evidenced			
	by:				.
		ns and staff interviews, the move expired items from 1		a. The policies Food Safety Produc Labelling and Dating Guidelines rev	
		2) provide an open/ use by		date 12/06/2022 and PQA (Product	
	date for food available	e for use in 1 of 1 walk in		Quality Assurance) Food Product S	helf
	refrigerators and 2 of	2 walk in freezers; (3)		Life Guidelines revision date 1/28/22	2 were

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	TE SURVEY MPLETED
		345386	B. WING		0	4/23/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
WILKES F	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC	28659	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE
F 812	Continued From page	e 25	F 81	2		
	available for use; and dried debris available	I (4) keep dishes free from for use. This deficient ntial to affect eight (8) of		supervisors and the m immediately begun ma monitor all items availa ensuring dating guidel Additionally, this monit	aking rounds daily to able for use ines are followed.	
	The findings included a. On 4/21/25 at 11:4	l: 5 AM with the Kitchen		confirming that open d dates are visible on the immediate compliance	lates and use by e products. For	
	observed with an exp	gallon of whole milk was iration date of 04/18/25 and in the reach in cooler.		of labeling with an ope date has been initiated ensure ongoing compl	d on 4/25/25. To	
		with the Kitchen Supervisor.		has ordered an electro This new electronic lat include an open date a	beling system will and a use by date.	
	use by date which inc	ad food open to air and no cluded broccoli, shredded and gravy. The walk-in		The new system will b within 90 days barring interruptions. The man	any shipping	
	refrigerator had the fo use-by date: one pac	bllowing food with no open or kage of American cheese, er jack cheese, half of a		continue until the elect available. All dietary st education regarding th	tronic system is taff received	
	5-pound (lb.) bag of c	-		process of proper dati Education will be provi	ng on 4/24/25.	
	or use-by date which cheddar cheese wrap wrap, one bag of unc	er #2 had food with no open included one package of oped in plastic clear cling ooked potato wedges, and		new staff. Compliance Daily monitoring by the manager will continue 60 days, random moni	e supervisor or for 60 days. After itoring by the	
	 one bag of uncooked omelets. c. Observation of the kitchen occurred on 4/21/25 at 11:45 AM with the Kitchen Supervisor. 			supervisor or manager Monitoring results will SNF QAA committee		
	stacked wet. At the r out of 8 plastic dome	are was put away and neal preparation station, 4 lids were stacked wet and		b. The policy Food Sat Labelling and Dating C date 12/06/2022 was r	Guidelines revision reviewed.	
	wet, and 4 out of 8 bo	ut of 15 trays were stacked owls were stacked wet.		Beginning 4/25/25, the the manager have imn making rounds daily to	nediately begun o monitor all items	
		kitchen occurred on with the Kitchen Supervisor. are in the meal preparation		available for use ensur guidelines are followed monitoring will include	d. Additionally, this	

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TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OMB NO. 0938- (X3) DATE SURVEY COMPLETED	
		345386			04/22/2020	
NAME OF P	ROVIDER OR SUPPLIER	040000		STREET ADDRESS, CITY, STATE, ZIP CODE	04/23/202	
WILKES F	REGIONAL MEDICAL CT	R SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659			
(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 APPF DEFICIENCY)	ULD BE COMPLE	
F 812	area and in the plate debris. 2 out of 6 plat available for use on t and 8 out of 15 plates available for use on t An interview with the 04/21/2025 at 11:45 <i>J</i> remove dirty plates p Supervisor explained thoroughly dried prior stack or use wet dish Supervisor continued responsible for prope	warmer contained dried food es with dry debris were he meal preparation station s with dry debris were he plate warmer. Kitchen Supervisor on AM revealed staff should rior to use. The Kitchen dishware should be to use. Staff should not	F 812	 open dates and use by dates are on the products. For immediate compliance, a manual process of with an open date and a use by dates are on the initiated. To ensure ongoing compliance the manager has order electronic labeling system. This melectronic labeling system will inclopen date and a use by date. The system will be available for use w days barring any shipping interrup. The manual process will continue electronic system is available. All staff received education regarding policy and process of proper datin 4/24/25. Education will be provide orientation of new staff. Compliar began on 4/25/25. Daily monitoring supervisor or manager will continue days. After 60 days, random monit the supervisor or manager will be Monitoring results will be reported SNF QAA committee. c. The policy Food Safety Manage System revision date 10-01-2024 reviewed. On 4/24/25, the managi reeducation on the importance of and dry dishes available for use in kitchen using the Food Safety Management System guidelines. 4/24/25, additional education was provided using the Ecolab Dish m procedures guidelines. Educatior provide in orientation of new staff. Compliance began on 4/25/25. Th supervisor monitors and inspects service ware daily to ensure it is origonal. 	labeling ate has gered an ew lude an e new ithin 90 ptions. until the dietary g the ag on ed in nee ng by the ue for 60 itoring by done. I to the ement was er began clean n the Also on achine n will be ff. ne all	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345386	B. WING		04/23/2025
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
	EGIONAL MEDICAL CT	R SN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTIO
F 812 F 814 SS=E	Dispose Garbage an CFR(s): 483.60(i)(4)	d Refuse Properly	F 812	 placed into use for patients. The dai monitoring by the supervisor or man will continue for 60 days. After 60 da random monitoring by the superviso manager will be done. Monitoring re will be reported to the SNF QAA committee. d. The policy Food Safety Managem System revision date 10-01-2024 wa reviewed. On 4/24/25, the manager reeducation on the importance of cle and dry dishes available for use in th kitchen using the Food Safety Management System guidelines. Als 4/24/25, additional education was provided using the Ecolab Dish mac procedures guidelines. Education wi provided in orientation of new staff .Compliance began on 4/25/25. The supervisor monitors and inspects all service ware daily to ensure it is cleat dry before being stored away or bein placed into use for patients. The dai monitoring by the supervisor or man will continue for 60 days. After 60 da random monitoring by the superviso manager will be done. Monitoring re will be reported to the SNF QAA committee. 	ager ays, r or sults hent as began ean he so on thine ill be an and ng ly ager ays, r or
	properly.	e of garbage and refuse Γ is not met as evidenced			

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	S FOR MEDICARE &				OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345386	B. WING		04/23/2025
NAME OF P	ROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CODE	
WILKES R	EGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 814	Continued From page	e 28	F 814		
		the area around the garbage		removed for appropriate disposal. As	
		cumulated trash and debris		April 25th 2025 a process was begun	
	for 1 of 1 garbage compactor observed.			monitor the back dock and trash area times daily by a staff member from	3
	The findings included	1:		dietary, environmental services, or	
	An observation was completed on of the garbage			engineering. Verbal education was	1
		/21/2025 at 12:40 PM. The		completed by Dietary Supervisor to al staff in these departments by 4/24/25	
	observation revealed	the following items outside		Education will be provided during	
		actor: 1 medium black		orientation for new staff. Compliance achieved as of 4/25/25. We will contir	
		nultiple blue latex gloves, 1 ard cones, 1 empty syringe,		this process for the next 60 days, after	
	1 small container of ι	unidentified food. A large		that we will monitor the area for	
		l large brown box was sitting		cleanliness once in the morning and c	once
	on the loading dock v compactor was locate			in the evening, as well as when any teammate visits the area for trash disposal.	
		Kitchen Supervisor on			
		I revealed the garbage by the whole hospital. The			
		as not aware that the			
	garbage area was the Services.	e responsibility of Kitchen			
	An interview with the	Nutritional Service Manager			
		0 AM revealed she was			
	unaware that the gar responsibility of Kitch	-			
	An interview with the	-			
		025 at 3:00 PM revealed she			
	responsibility of Kitch	e garbage area was the nen Services.			
F 880 SS=E	Infection Prevention	& Control	F 880		5/22/25
	§483.80 Infection Co	ntrol			
			1	1	1

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/23/2025 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	
		345386	B. WING _			04/	23/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	REGIONAL MEDICAL CTR	R SN			1370 WEST D STREET NORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	infection prevention a designed to provide a comfortable environm development and tran- diseases and infection §483.80(a) Infection p program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A syste reporting, investigatin and communicable di staff, volunteers, visite providing services un- arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable disease reported; (iii) Standard and tran- to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura	and control program a safe, sanitary and bent and to help prevent the asmission of communicable ns. brevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ig, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.71 and following ndards; e standards, policies, and ogram, which must include, llance designed to identify ble diseases or c can spread to other ; m possible incidents of se or infections should be asmission-based precautions rent spread of infections; blation should be used for a t not limited to:	F	880			

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								
TATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED		
		345386	B. WING			04/	23/2025		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•			
WILKES F	REGIONAL MEDICAL CT	R SN			70 WEST D STREET				
	1			NC	DRTH WILKESBORO, NC 28659				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 880	Continued From pag	e 30	F	880					
		at the isolation should be the							
		ible for the resident under the							
	circumstances.								
	(v) The circumstance	es under which the facility							
		ees with a communicable							
		kin lesions from direct							
		s or their food, if direct							
	contact will transmit								
		e procedures to be followed irect resident contact.							
		em for recording incidents acility's IPCP and the ken by the facility.							
	0.400.00(.).1.								
	§483.80(e) Linens.	dle, store, process, and							
		s to prevent the spread of							
	infection.	s to prevent the spread of							
	§483.80(f) Annual re	view.							
		uct an annual review of its							
	· ·	eir program, as necessary.							
		T is not met as evidenced							
	by:	income and staff intermination that			A maximum of management for lafe stick				
	facility failed to imple	view and staff interviews, the			A review of processes for Infection Prevention and Control was conducted	he			
		monitoring and tracking			with the Infection Team on $4/23/25$.				
		ity. This practice had the			Effective 5/21/25, WMC SNF will follo	w			
		of 8 residents in the facility.			the CDC NHSN Long-Term Facility				
		2			Component Manual for Tracking				
	Findings included:				Healthcare-Associated Infections (HA	Als)			
					in Long-Term Care Facilities, dated				
		on Prevention and Control			January 2023. Per this document				
		dated 2/1/25 documented the			acceptable methods for performing				
		st (IP) conducts surveillance			outcome surveillance will be followed				
		ng residents and partners			specifically comprehensive and targe	ted.			
		d analysis of outbreaks of			As outlined per this best practice				
	infections.				guidance, several factors will be				

Event ID: UH8N11

Facility ID: 943561

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					OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED		
		345386	B. WING		04/23/2025		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WILKES F	REGIONAL MEDICAL CT	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIC		
F 880	Continued From page	31	F 88	0			
	Record review indicat antibiotics for osteom receiving antibiotics for The Infection Prevent interviewed on 4/23/2 discussed tracking an skilled nursing unit by form. She explained t so she did not have a provided computerize infections that were re Line associated blood associated urinary tra methicillin-resistant st difficile(C-Diff), Surgid showed only one infe- year. She reported track flu, pneumonia, associated infections. hospital and nursing f was able to pull only i home. The Unit Nurse Mana 4/23/25 at 10:30 AM. explained the IP nurs infection surveillance/ had been at least one ago, as well as other reported covid-19 was was transferred out to she expected the IP n	ted Resident #2 receiving yelitis and Resident #4 or a wound infection. ionist (IP) nurse was 5 at 9:15 AM. The IP nurse ad analyzing infections in the r using an approved tracking he form was computerized, paper copy for review. IP ad information for five egularly tracked, Central dstream infection, catheter act infections, taphylococcus, Clostridium cal Site Infection. This data ction on the unit in the last that the system does not covid-19 or non-catheter . This system tracked both nome infections, however, IP nformation for the nursing ger was interviewed on The Unit Nurse Manager e was responsible for (tracking and she knew there e case of covid-19, 2 weeks infections on the unit. She s not treated on the unit and o the hospital. She stated nurse to perform infection on all the residents who		considered when determining which method to implement, such as staff available resources, the frequency of events being monitored and the IPC program surveillance goals. An ann risk assessment is performed to eva and provide guidance on priority for areas for the facility. Surveillance, monitoring and tracking of infections the facility will be achieved through multiple means of targeted data coll as stated per the NHSN Long-Term Facility Component Manual for Trac Healthcare-Associated Infection in Long-Term Care Facilities. The Infe Control nurse and SNF nursing staff receive education on infection surve plan for monitoring and tracking infe- in the facility by 5/21/25 with a comp completion date of 5/22/25 . The Inff Prevention Plan Policy (WMC) date 16, 2025, on pages 4-5 and page 10 addresses the targeted infection surveillance that will be performed a with the surveillance plan utilizing th following Surveillance Reports GI Panel Report High Priority Reportable Conditions Reportable Other Conditions Teammate Exposures ICON Covid Surveillance Influenza Report COVID/Influenza Death Report Isolation List Infection List CAUTI Lab ID CLABSI Lab ID Blood culture C. Diff	time, of c ual aluate cus s for lection ction f will eillance ections pliance fection d April 6 along ne		

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					OMB NO. 0938-03		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345386	B. WING		04/23/2025		
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
WILKES F	REGIONAL MEDICAL CTR	RSN		370 WEST D STREET IORTH WILKESBORO, NC 28659			
(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 COMPLETIC		
F 880	Continued From page	32	F 880	MRSA SSI (Colo, HPRO, KPRO)			
F 883 SS=E		ococcal Immunizations (2)	F 883		5/22/25		
	policies and procedur (i) Before offering the each resident or the r receives education re potential side effects of (ii) Each resident is of immunization October annually, unless the in contraindicated or the immunized during this (iii) The resident or the has the opportunity to (iv)The resident's med documentation that in following: (A) That the resident was provided education and potential side effect immunization; and (B) That the resident immunization or did n immunization due to r refusal. §483.80(d)(2) Pneum must develop policies that- (i) Before offering the	za. The facility must develop es to ensure that- influenza immunization, esident's representative garding the benefits and of the immunization; ffered an influenza r 1 through March 31 mmunization is medically resident has already been time period; e resident's representative or fuse immunization; and dical record includes dicates, at a minimum, the or resident's representative on regarding the benefits ects of influenza either received the influenza nedical contraindications or ococccal disease. The facility and procedures to ensure pneumococcal esident or the resident's					

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/23/2025 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345386	B. WING			04/	23/2025
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
	EGIONAL MEDICAL CT	P SN		13	70 WEST D STREET		
MEREOR				NC	ORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETION DATE
F 883	Continued From page 33		F i	883			
	benefits and potentia immunization; (ii) Each resident is o immunization, unless medically contraindic already been immuni (iii) The resident or th has the opportunity to (iv)The resident's me documentation that in following: (A) That the resident was provided educati and potential side effi immunization; and (B) That the resident pneumococcal immuni the pneumococcal immuni contraindication or resident	I side effects of the ffered a pneumococcal the immunization is ated or the resident has zed; the resident's representative or refuse immunization; and dical record includes indicates, at a minimum, the or resident's representative ion regarding the benefits the benefits					
	facility failed to docur in the medical record potential side effects pneumonia vaccines. residents (Resident # Resident #159) revier The findings included a. Resident #210 w 04/17/25.	This occurred for 3 of 5 210, Resident #110, and wed for vaccines. I: vas admitted to the facility on num Data Set assessment			Corrective Action for Affected Resider For Affected Residents identified on 4/23/25 vaccine education was provid indicating the benefits and potential si effects of the COVID-19, Influenza, ar Pneumococcal vaccines. Identification of Other Residents at Ri- Beginning 4/30/25 COVID-19, Influenz (when in season), and Pneumococcal vaccine education is provided to every resident, and document in the medical record. Systemic Changes to Prevent Recurrence: Education regarding the benefits and	ed de nd sk: za /	
	The resident's immur	nization record was reviewed			Education regarding the benefits and potential side effects of the COVID-19),	

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		MEDICAID SERVICES				<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		E SURVEY IPLETED
		345386	B. WING		04	4/23/2025
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
WILKES F	REGIONAL MEDICAL CTR	R SN		1370 WEST D STREET NORTH WILKESBORO, NC 28659)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 883	Continued From page	234	F 88	33		
	 and revealed that flux resident was due the Resident #210 had de vaccine. The immuniz revealed that nothing education notes sective record. Interview with Reside PM revealed she dece pneumonia vaccine, a vaccine was up to date remember being educe receiving them. b. Resident #110 we 4/14/25. The admission Minim dated 4/21/25 showed cognitively intact 	vaccine was current, but the pneumonia vaccine and eclined the pneumonia zation record review also was documented under the on on the immunization nt #210 on 4/22/25 at 2:45 lined any additional and she reported her flu te. She reported she did not cated on the risk of her not as admitted to the facility on um Data Set assessment d the resident to be		 Influenza (when in season), Pneumococcal vaccine is prevery resident to the facility appropriate documentation in Nursing Staff Education incluination in Staff Education regarding the potential side effects of the Confluenza (when in season), Pneumococcal vaccine is prevery resident upon admissi facility regardless of accepta vaccine. Appropriate documenta RN or LPN in the Medical Reprovision of vaccine education 3. Nursing Education will be incorporated into new staff of plan. Education to be complete 5/21/25. 	ovided to and s completed. udes: benefits and COVID-19, and ovided to on to the ance of tion by SNF ecord of on be vrientation ted by	
	and revealed the resid and flu vaccine. Revia record also revealed i under the education r immunization record. Resident #110 decline 4/21/25 at 11:00 AM. c. Resident #159 w 4/12/25. The admission Minim dated 4/19/25 showed	nt #110 declined to be interviewed on at 11:00 AM. sident #159 was admitted to the facility on		 Monitoring and Quality Assue Charge Nurse or a designee 1. As of 5/21/25 conduct 1 all new admissions for provise COVID-19, Influenza (when and Pneumococcal vaccine and documentation of the preducation in the Medical Re- next 60 days with random re- thereafter to ensure ongoing 2. Results will be reviewed both nurse manager and char and at each QAA meeting. 3. Any trends or recurrent prompt immediate re-education 	e too: 00% review of sion of in season), education, ovision of cord for the eviews compliance. d monthly by arge nurses issues will	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE C	ONSTRUCTION	· · ·	TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG		CO	MPLETED
		345386	B. WING _			0	4/23/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	EGIONAL MEDICAL CT	R SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659				
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 883	Continued From page	e 35	F	383			
	The resident's immur and revealed he had vaccine. Review of the revealed nothing was	nization record was reviewed refused flu and pneumonia ne immunization record also s documented under the ion on the immunization			See attachments for directed POC		
	Interview with Reside PM revealed he refus vaccine. He reported getting any education						
	on 4/23/25 at 10:40 A nurse would administ Medication Administr stated there should b administration of the administering the vac "education section" o resident declined edu as to the risk of not b	Infection Preventionist (IP) AM revealed that the floor ter the vaccines per the ation Record (MAR). She be education provided prior to vaccine by the nurse coine and documented in the of the resident's chart. If the fucation should be provided being vaccinated. IP reports y this had not been done.	st (IP) floor he She I prior to d in the If the vided eports				
	4/23/25 at 12:30 PM should be provided to resident's representa being administered. S was for the nurse that document in the med had been provided of the resident declined noted in their chart all not being vaccinated	Unit Nurse Manager on revealed that education to the residents or the tive prior to the vaccine She stated the expectation it provided the education to lical record that education in the immunization record. If the vaccine, it should be long with education for risk of . Unit Nurse Manager reports y this had not been done.					

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		MEDICAID SERVICES			OMB N	<u>10. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED
		345386	B. WING		0	4/23/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
	EGIONAL MEDICAL CT	R SN		1370 WEST D STREET		
				NORTH WILKESBORO, NC 28659		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 883	Continued From pag	e 36	F 88	22		
1 000		e so ntry person". Vaccines were	ГОС	55		
		nt and if the resident agrees				
		an order was created and				
		on Administration Record. If				
	the resident declines	the vaccines the process				
	stopped with the dec	lination.				
F 887	37 COVID-19 Immunization		F 88	37		5/22/25
SS=E	CFR(s): 483.80(d)(3))(i)-(vii)				
	§483.80(d) (3) COVI	D-19 immunizations. The				
	LTC facility must dev	elop and implement policies				
		nsure all the following:				
		vaccine is available to the				
	facility, each residen	t and staff member				
		ically contraindicated or the				
		her has already been				
	immunized;	·····				
	(ii) Before offering C	OVID-19 vaccine, all staff				
	members are provide					
		s and risks and potential side				
	effects associated wi					
	resident or the reside	OVID-19 vaccine, each				
		egarding the benefits and				
		de effects associated with				
	the COVID-19 vaccir					
		re COVID-19 vaccination				
	requires multiple dos					
	-	ve, or staff member is				
	-	t information regarding those luding any changes in the				
		potential side effects				
		COVID-19 vaccine, before				
		or administration of any				
	additional doses;	-				
		dent representative, or staff				
	member has the opp	ortunity to accept or refuse a				

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PRINTED: 05/23/2025 FORM APPROVED

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				FOF	ED: 05/23/202 RM APPROVE O. 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345386	B. WING		04	4/23/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	=	
WILKES R	EGIONAL MEDICAL CT	R SN		1370 WEST D STREET		
				NORTH WILKESBORO, NC 28659		
(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 COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 887	Continued From page	e 37	F 88	7		
	COVID-19 vaccine, a	and change their decision;				
		edical record includes				
		ndicates, at a minimum,				
	the following:					
		or resident representative				
	was provided educat	5 5				
	COVID-19 vaccine; a	I risks associated with				
	,	VID-19 vaccine administered				
	to the resident; or					
		I not receive the COVID-19				
	vaccine due to medic	cal				
	contraindications or r					
	• •	tains documentation related				
	to staff COVID-19 va					
	includes at a minimu					
	the benefits and pote	rovided education regarding				
	associated with COV					
		the COVID-19 vaccine or				
	()	ing COVID-19 vaccine; and				
		accine status of staff and				
	related information a	s indicated by the Centers for				
	-	Prevention's National				
	Healthcare Safety Ne	, ,				
		T is not met as evidenced				
	by: Based on record rev	view, resident, and staff		Corrective Action for Affected	Residents	
		/ failed to document that		For Affected Residents identifi		
		led in the medical record		4/23/25 vaccine education wa		
		s and potential side effects		indicating the benefits and pot		
	of the COVID-19 vac	cines. This occurred for 4 of		effects of the COVID-19, Influ		
		for immunizations (Resident		Pneumococcal vaccines.		
		, Resident #159, Resident				
	#4).			Identification of Other Resider		
	The findings include	4.		Beginning 4/30/25 COVID-19,		
	The findings included	1.		(when in season), and Pneum vaccine education is provided		
		vas admitted to the facility on		resident, and document in the		

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345386	B. WING		0	4/23/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1370 WEST D STREET		
WILKES F	REGIONAL MEDICAL CTI	RSN		NORTH WILKESBORO, NC 28659		
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 887	Continued From page 4/17/25.	38	F 88	37 record.		
	dated 4/17/25 showed cognitively intact. The Resident's immureviewed and revealed declined the covid vare record review also revide a state of the covid vare record review also revide a state of the covid vare documented under the on the immunization of the immunization of the covid vare on 4/22/25 at 2:45 PM any additional covid vare member being educated of the covid vare of the covid	nization record was d that the resident had ccine. The immunization vealed that nothing was e education notes section record for this vaccine. dident #210 was conducted <i>A</i> and revealed she declined raccines and she did not cated on the risk of her not as admitted to the facility on um Data Set assessment d the resident to be ization record was reviewed resident declined the covid resident declined the covid resident declined the covid resident declined under the on on the immunization		 Systemic Changes to Prevent Recurrence: Education regarding the benefic potential side effects of the CC Influenza (when in season), and Pneumococcal vaccine is provievery resident to the facility and appropriate documentation is of Nursing Staff Education include 1. Education regarding the bic potential side effects of the CC Influenza (when in season), and Pneumococcal vaccine is provievery resident upon admission facility regardless of acceptance vaccine. Appropriate documentation will be incorporated into new staff or its plan. Education to be completed 5/21/25. Monitoring and Quality Assurate Charge Nurse or a designee to 1. As of 5/21/25 conduct 100 all new admissions for provision of the completed 5/21/25. Monitoring and Quality Assurate Charge Nurse or a designee to 1. As of 5/21/25 conduct 100 all new admissions for provision of the provision of the	DVID-19, ad ided to d completed. es: enefits and DVID-19, ad ided to to the ce of n by SNF ord of entation d by nce po: 	
		as admitted to the facility on		education in the Medical Reco next 60 days with random revie thereafter to ensure ongoing c 2. Results will be reviewed n	ews ompliance.	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 05/23/2025 MAPPROVED). 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION	(X3) DATE	
		345386	B. WING			04/	23/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
WILKES R	EGIONAL MEDICAL CTF	RSN			370 WEST D STREET IORTH WILKESBORO, NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 887	dated 4/19/25 showed moderately cognitively The resident's immun and revealed the resid vaccine. Review of the revealed nothing was education note section record for this vaccine. An interview with Ress 4/22/25 at 3:00 PM ret the covid vaccine. He remember getting any vaccine. d. Resident #4 was 3/3/25. The admission Minim dated 3/10/25 showed cognitively impaired. The resident's immun and revealed the resid vaccine. Review of the revealed nothing was education notes section record for this vaccine. An interview with Ress 4/22/25 at 3:15 PM are further covid vaccinat	um Data Set assessment d the resident to be y impaired. ization record was reviewed dent agreed to the covid e immunization record documented under the n on the immunization e. ident #159 conducted on vealed he agreed to have reported he did not y education regarding the admitted to the facility on um Data Set assessment d the resident to be ization record was reviewed dent refused the covid e immunization record also documented under the on on the immunization e. ident #4 was conducted on nd indicated he declined any	F	887	both nurse manager and charge nurse and at each QAA meeting. 3. Any trends or recurrent issues wil prompt immediate re-education and process review. Target Full Compliance Date: 5/22/25		

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/23/2025 / APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345386	B. WING			_	04/	23/2025
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
WILKES F	REGIONAL MEDICAL CTF	R SN			1370 WEST D STREET NORTH WILKESBORO, I	NC 28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 887	on 4/23/25 at 10:40 A would administer the Administration Record should be education p administration of the administration of the administering the vac "education section" of resident declined the be provided as to the She reports she is un documented. An interview with Nur- 2:00 PM indicated that entered by a "data en offered to the residen to have the vaccine a sent to the Medication the resident declined stopped with the declined stopped with the declined should be provided to resident's represent being administered. S was for the nurse that document in the medi had been provided or the resident declined noted in their chart all not being vaccinated.	Infection Preventionist (IP) M revealed the floor nurse vaccines per the Medication d (MAR). She stated there provided prior to vaccine by the nurse cine and documented in the f the resident's chart. If the vaccine, education should risk of not being vaccinated. sure why education was not se Navigator on 4/22/25 at at immunizations were try person". Vaccines were t and if the resident agreed n order was created and n Administration Record. If the vaccines the process ination. Unit Nurse Manager on revealed that education	F	887				

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