STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/04/25 through 05/07/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # UGXN11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 05/04/25 through 05/07/25. Event ID# UGXN11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the area of falls (Resident #32) for 1 of 3 residents reviewed for accidents. The findings included: Resident #32 was admitted to the facility on 11/26/24 with diagnoses that included a history of a fracture to the right knee and muscle weakness. A review of Resident #32's medical record revealed she had a self-reported fall on 1/3/25 that resulted in a skin tear to her left hip since the Admission MDS assessment on 12/2/24. A quarterly MDS assessment dated 2/4/25 indicated that Resident #32 was cognitively intact.	F 641	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1A. On 05/07/25, the Minimum Data Set nurse #2 modified the assessment for resident #32. 1B. On 05/08/25, the Minimum Data Set nurse #1 submitted the correction for resident #32 to the Centers for Medicaid/Medicare Services. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2A. On 05/08/25, the Director of Nursing along with Minimum Data Set Nurse #2 conducted an audit of all residents currently in the facility that have experienced a fall from 11/01/24-05/07/25. Discrepancies identified during the audit	5/22/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/21/2025

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F 641	Continued From page 1 She was not coded with any falls since the last assessment. On 5/6/25 at 10:19 AM, an interview occurred with the MDS Nurse #2 who reviewed the MDS assessment dated 2/4/25 as well as Resident #32's medical record. MDS Nurse #2 confirmed Resident #32 had a documented fall with a skin tear on 1/3/25 and should have been coded as a fall with minor injury. She stated it was an oversight. The Director of Nursing was interviewed on 5/6/25 at 1:42 PM and stated that it was her expectation for the MDS to be coded accurately in the area of falls.	F 641	were corrected. 2B. On 05/08/25, the Minimum Data Set nurse #1 submitted the corrections for discrepancies identified during the audit conducted by the Director of Nursing on 05/08/25, to the Centers for Medicaid/Medicare Services. 3. Address what measures will be put into place of systemic changes made to ensure that the deficient practice will not recur: 3A. On 05/13/25, both Minimum Data Set Nurses were re-educated by the Regional Clinical Reimbursement specialist on J1800/J1900 of the Resident Assessment Instrument Guidelines for coding falls. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4A. An audit in the area of falls on the Minimum Data Set will be conducted by the Licensed Nursing Home Administrator or her designee weekly for 8 weeks then monthly for 3 months. Results of the audits will be brought to the Quality Assurance Performance Improvement meetings held monthly. If any discrepancies are noted, further action will be implemented by the Licenses Nursing Home Administrator.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		5/22/25

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F 656	Continued From page 2 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 3 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to develop an individualized person-centered care plan in the area of smoking for 1 of 1 resident reviewed for smoking (Resident #58). The findings included: Resident #58 was admitted to the facility on 03/24/25 with diagnoses that included wedge compression fracture of first lumbar vertebra, hypertension, and pain. The admission Minimum Data Set (MDS) assessment dated 03/28/25 indicated Resident #58's cognition was intact. The MDS indicated Resident #58 used tobacco. Review of Resident #58's active care plan, dated 04/30/25, revealed no care plan related to smoking. An observation and interview were conducted on 05/06/25 from 8:55 AM through 09:20 AM with Resident #58 in the smoking area. She safely lit, smoked, discarded ashes and disposed of cigarette safely. No concerns were observed with Resident #58 while she was smoking. She stated she had smoked since she was admitted to the facility. An interview was conducted on 05/07/25 at 8:32 AM with MDS Coordinator #2. She verified there were no areas on Resident #58's care plan to include smoking until 05/06/25. She stated it was an oversight that this was not added on Resident	F 656	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1A. On 05/06/25, the Minimum Data Set nurse #2 entered a care plan for smoking on resident #58. 1B. On 05/07/25, the Director of Nursing reviewed the Comprehensive Care Plan for resident #58 for accuracy, no issues identified. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2A. On 05/08/25, the Director of Nursing conducted an audit of all current smoking residents for a comprehensive smoking care plan, no issues identified. 3. Address what measures will be put into place of systemic changes made to ensure that the deficient practice will not recur: 3A. On 05/13/25, both Minimum Data Set Nurses were re-educated by the Regional Clinical Reimbursement specialist on Resident Assessment Instrument chapter 4 for Comprehensive Guidance of the Care Plan Process. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4A. An audit of smoking comprehensive care plans will be conducted by the Licensed Nursing Home Administrator or her designee Weekly for 8 weeks then monthly for 3 months. Results of the	

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F 656	Continued From page 4 #58's care plan prior to 05/06/25. An interview was conducted on 05/07/25 at 8:52 AM with the Director of Nursing. She indicated Resident #58's care plan should have included a focus related to smoking. An interview was conducted on 05/07/25 at 9:02 AM with the Administrator. She stated Resident #58's care plan should have included a focus related to smoking.	F 656	audits will be brought to the Quality Assurance Performance Improvement meetings held monthly. If any discrepancies are noted, further action will be implemented by the Licenses Nursing Home Administrator.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transcribe the correct route of medication administration for 1 of 1 resident reviewed with gastric feeding tube (Resident #2). The findings included: Resident #2 was originally admitted to the facility on 10/30/20 with diagnoses that included cerebrovascular disease, and dysphagia (difficulty swallowing). Resident #2 had recently been hospitalized from 4/4/25 through 4/6/25. A quarterly Minimum Data Set (MDS) assessment dated 4/10/25 indicated Resident #2 had severely impaired cognition, had a feeding tube and received all nutrition and fluids via a	F 658	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1A. On 05/06/25, the unit manager contacted the medical director, reviewed resident #2 medications, and corrected 3 medications to be dispensed by gastrostomy tube. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: 2A. On 05/07/25, the unit manager reviewed the remaining three residents in the facility with gastrostomy tubes orders and corrected any discrepancies immediately.	5/22/25

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F 658	Continued From page 5 feeding tube. Review of Resident #2's active care plan, last reviewed 4/25/25, included a focus area for being at risk for nutrition and dehydration due to nothing by mouth (NPO) status and tube feed. The active May 2025 physician orders included the following orders: - An order dated 4/6/25 read; NPO - An order dated 4/6/25 for Briviact (an antiseizure medication) 10 milligrams (mg) per milliliter (ml). Give 10 ml orally twice a day. - An order dated 4/7/25 for Hydrocodone-Acetaminophen 5-325 mg one tablet orally three times a day as needed. - An order dated 4/7/25 for Lacosamide (an antiseizure medication) 10 mg per ml. Give 15 ml orally twice a day. All other medications were written to be provided through the gastric feeding tube. On 5/6/25 at 9:26 AM, an interview occurred with Nurse #1 who had transcribed the order for Briviact on 4/6/25. She explained that she entered the medication, dose and frequency into the Electronic Medical Record (EMR) but failed to change the medication route to gastrostomy tube (G-tube). She stated the system default route was oral. On 5/6/25 at 9:39 AM, an interview was conducted with the Unit Manager who had transcribed the orders for Hydrocodone-Acetaminophen and Lacosamide on 4/7/25. He explained that he entered the medication, dose and frequency into the EMR but failed to change the medication route to via	F 658	2B. On 05/07/25, the unit manager and the assistant director of nursing reviewed all of the remaining residents for the correct routes of administration. No discrepancies were identified in the area of by mouth or gastrostomy tube. . 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 3A. On 05/07/25, the Director of Nursing provided General Guidelines for Transcribing Orders onto the Medication Administration Record for 100% of the nurses. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4A. An audit on correct route of administration Of five residents will be conducted by the Director of Nursing or her designee weekly for 8 weeks, then monthly for 3 months. Results of the audits will be brought to the Quality Assurance Performance Improvement meetings held monthly. If any discrepancies are noted, further action will be implemented by the Licensed Nursing Home Administrator.	

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F 658	Continued From page 6 G-tube. He explained the EMR system default route was oral. An interview occurred with Nurse #2 on 5/6/25 at 11:00 AM. She was working the medication cart for Resident #2's hall and had administered Resident #2's medications earlier. Nurse #2 confirmed that Resident #2 did not receive any medications orally and she had not provided the morning doses of Briviact or Lacosamide by mouth. The Director of Nursing (DON) was interviewed on 5/6/25 at 1:42 PM. She reviewed Resident #2's physician orders and confirmed the route for the Briviact, Hydrocodone-Acetaminophen and Lacosamide were entered as oral instead of via G-tube. She further explained that when entering the medications into the EMR the default route was oral, and she felt it was an oversight that the nursing staff failed to change the route to G-tube. The DON stated it was her expectation for all medication administration routes to be entered correctly when the order was received.	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		5/22/25

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F 812	Continued From page 7 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to discard leftover food stored past the use by date in 1 of 1 walk-in cooler. The facility also failed to label and date leftover frozen food removed from its original packaging in 1 of 1 reach-in freezer and 1 of 1 deep freezer. This practice had the potential to affect food served to residents. The findings included: Observations during the initial tour of the main kitchen with Dietary Aide #1 on 05/04/25 at 11:03 AM, revealed the following: a. In the reach-in freezer the following leftover frozen food removed from its original packaging were observed: -1/4 bag of beef riblets with no label or date. -1/2 of large bag of fish fillets with no label or date. An interview was conducted on 05/04/25 at 11:10 AM with Dietary Aide #1. She stated a date should have been written on the bags of leftover frozen foods when they were opened. She stated whoever opened the items were the ones	F 812	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1A. On 05/04/25, the dietary manager met with the surveyor, all items that the surveyor brought to her attention that were not in compliance were removed immediately. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2A. On 05/07/25, the Licensed Nursing Home Administrator conducted an audit of both refrigerators and freezer, no issues identified. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: 3A. On 05/07/25, the dietary manager educated all the kitchen staff on the Storage of Frozen Foods policy, Freezers and Refrigerators Policy, and Storage of Refrigerated Foods policy. 3B. On 05/14/25, the Licensed Nursing Home Administrator re-educated the dietary manager on failure to train her staff appropriately related to dating food	

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F 812	Continued From page 8 responsible for writing the open date on it. She indicated the Dietary Manager checks the freezers and coolers daily. b. In the deep freezer the following leftover frozen food removed from its original packaging was observed on 05/04/25 at 11:15 AM with the Dietary Manager. -1/4 bag of mixed vegetables with no label or date. c. In the walk-in cooler the following items were observed on 05/04/25 at 11:25 AM with the Dietary Manager. - one gallon size bag of corn bread pieces with an open date of 04/24/25. - one gallon size bag with 20 precooked crescent rolls with an open date of 04/19/25. There were white and blue fuzzy spots present on 2 of the crescent rolls. - two 14 oz bags of mini bagels with an open date of 04/15/25. An interview was conducted on 05/04/25 at 11:25 AM with the Dietary Manager. She explained when an item was opened the date should be written on the item at that time. The Dietary Manager also stated items in the cooler should be discarded within 7 days. Items in the freezer should include date of delivery and an open date upon opening the item. An interview was conducted on 05/06/25 at 11:32 AM with Dietary Cook #2. She stated food items in the cooler should be discarded after 7 days	F 812	items and discarding foods, per policy. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: 4A. The Licensed Nursing Home Administrator or her designee will audit both refrigerators and the freezer for food properly stored/labeled/dated, and the foods are within date. The audit will be conducted weekly for 8 weeks, and then monthly for 3 months. Results of the audits will be brought to the Quality Assurance Performance Improvement meetings held monthly. If any discrepancies are noted, further action will be implemented by the Licensed Nursing Home Administrator.	

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F 812	Continued From page 9	F 812		

and all food items should be dated when they were opened. The also stated the Dietary Manager checks the coolers and freezers daily for dated and/or expired food items.

A follow-up interview was conducted on 05/06/25 at 11:42 AM with the Dietary Manager (DM). She stated she was responsible for monitoring the freezer and coolers for dated and labeled food items. She explained the cooks could also check for dated, expired, or labeled items but there was no one assigned to perform the tasks. She indicated staff turnover could have been a reason for food items not being dated upon opening in the freezers and items not being discarded after 7 days in the coolers. She then stated that the kitchen cooks and aides were to put the leftover food in an airtight container/baggy and write their initials and open date on the containers and store in the cooler. The DM indicated that all frozen foods must be dated to ensure proper rotation by expiration dates.

An interview was conducted on 05/07/25 at 9:02 AM with the Administrator. She stated she was unaware that dietary staff were not labeling or dating opened food items and that they were not discarding opened food items within 7 days. She explained that she expected the Dietary Manager and kitchen staff to properly label, date, and discard prepared food items per regulations and for education to be provided during orientation and reeducation to current staff as needed.