STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		3/2/18

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

Electronically Signed | 02/22/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview, and staff interview, the facility failed to treat residents with dignity and respect by failing to knock on the door and/or entering a resident ' s room without their permission during patient care (Resident #83) and by utilizing the label "feeder" to describe a resident (Resident #10) who required assistance with eating for 2 of 5 residents reviewed for dignity. The findings included: 1. Resident #83 was admitted to the facility on 7/13/16 and most recently readmitted to the facility on 11/20/17 with diagnoses that included paraplegia and acquired absence of left leg above the knee. The quarterly Minimum Data Set (MDS) assessment dated 11/28/17 indicated his cognition was fully intact. He had no behaviors and no rejection of care. Resident #83 ' s plan of care included, in part, the focus area of choosing to be highly involved in his daily care. The interventions included honoring his individual choices and preferences as able. This focus area and intervention were initiated on 12/14/17. An interview was conducted with Resident #83 on 1/29/18 at 3:05 PM. During this interview, the resident ' s door was opened partway by Nursing Assistant (NA) #2, she observed the interview in process, and then closed the door. There was no audible knock heard prior to NA #2 entering the	F 550	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F550 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Staff re-education given to all staff including PRN, weekend, and agency by SDC (Staff Development Coordinator) and/or DON (Director of Nursing) and/or ADON (Assistant Director of Nursing) on resident□s rights with a focus on dignity, respect, and privacy to be completed by March 2, 2018. Staff education will be completed prior to staff working on the floor. It is alleged the facility failed to treat residents with dignity and respect by failing to knock on the door and/or entering a residents□ room without their permission during patient care (Resident #83) and by utilizing the label feeder to describe a resident who required assistance with eating (Resident #10). 2.The procedure for implementing the acceptable plan of correction for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 room and NA #2 was not given permission by Resident #83 or by his roommate to open the closed door. Following this event, Resident #83 indicated it made him angry when staff entered the room without knocking and/or without being invited in. Resident #83 then proceeded to speak about an event that he believed happened about a week ago. He stated the Wound Nurse was providing him with treatment when another staff member, unable to recall the staff member ' s name, opened the door. Resident #83 reported the Wound Nurse said, "patient care", but the other staff member came into the room anyway and was talking to the Wound Nurse while she was in the middle of providing care. He indicated the curtain was pulled, but that it still bothered him that she came into the room without knocking, without being invited in, and then continued to talk to the Wound Nurse during care. An interview was conducted with NA #2 on 1/30/18 at 2:10 PM. She was asked about the incident on 1/29/18 in which she opened Resident #83 ' s closed door without knocking and without being given permission to open the door by Resident #83 or his roommate. NA #2 denied not knocking on Resident #83 ' s door. She stated she had knocked lightly and it must not have been heard. She indicated she had been told in the past she knocked softly on doors. An interview was conducted with the Wound Nurse on 1/31/18 at 9:20 AM. She stated she was familiar with Resident #83 and she provided him with wound care. She indicated he was alert, oriented, and reliable. She verified the statement Resident #83 made during the interview on 1/29/18 in which he spoke about a staff member entering his room while wound care was being	F 550	specific deficiency cited. a)Staff should treat residents with dignity and respect. Staff re-education on resident□s rights with a focus on dignity, respect, and privacy to be completed by March 2, 2018. Staff is educated upon hire on resident rights including treating residents with dignity and respect and provision of privacy. Staff is re-educated annually on resident rights including treating residents with dignity, respect and provision of privacy. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The DON and/or Unit Coordinators will complete observation audits on 10 residents per week, to include all shifts and weekends, X 12 weeks. b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 provided. The Wound Nurse stated she believed the event happened about a week ago. She indicated she was providing wound care to Resident #83 in his room, the curtain was pulled, and the door was closed. She reported she was about halfway finished with providing Resident #83 ' s wound care when a staff member, unable to recall her name, knocked on the door. She stated she called out "patient care" and the staff member still opened the door and entered the room. The Wound Nurse reported the staff member stood on the outside of the curtain and proceeded to ask her a few questions while she was providing wound care to Resident #83. She indicated she then told the staff member she would find her when she was finished providing care. She stated she believed the staff member was in the room for less than a minute. The Wound Nurse indicated the staff member had not had visual sight of the resident as the curtain was pulled, but that Resident #83 was a very private man and voiced his unhappiness with the event by stating something like, "why couldn ' t that wait", after the staff member had left. She stated the staff member should have waited outside in the hallway when she called out "patient care". She reported if it was an emergent need the staff member could have asked for Resident #83 ' s permission to come in and ask her a question during his care. An interview was conducted with Nurse Unit Manager (UM) #1 on 1/31/18 at 10:25 AM. She indicated she was familiar with Resident #83. She stated he was a very private and proud man. She reported if his door was closed staff were to knock on the door and wait until he let you know if it was okay to enter.	F 550	5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4	F 550		

An interview was conducted with Social Worker (SW) #1 on 1/31/18 at 10:30 AM. He stated for all residents, if the room to their door was closed the staff member was to knock on the door and wait for permission to enter. He reported if another staff member was present in the resident ' s room and they said, "patient care", then the room was not to be entered until care was completed.

An interview was conducted with the Social Services Director on 1/31/18 at 10:33 AM. She stated it was her expectation for staff to knock on a resident ' s door and wait for the resident to give permission to enter the room prior to entering. She reported if another staff member was present in the resident ' s room and they said, "patient care", then the room was not to be entered until care was completed.

An interview was conducted with the Director of Nursing on 2/1/18 at 12:25 PM. She stated it was her expectation for staff to knock on a resident ' s door and wait for permission to enter the room. She additionally stated she expected staff to wait outside of the room if patient care was being provided.

2. Resident #10 was admitted to the facility on 10/30/14 with diagnoses that included dementia, adult failure to thrive, hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness of one side of the body) following cerebrovascular disease.

The quarterly Minimum Data Set (MDS) assessment dated 1/12/18 indicated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 5	F 550		

#10 ' s cognition was moderately impaired. She was dependent on one staff for assistance with eating. Resident #10 had impairment noted to both sides of her upper and lower extremities.

The plan of care for Resident #10 included, in part, the focus area of requiring assistance of staff for Activities of Daily Living (ADLs) secondary to limited mobility, hemiplegia and hemiparesis, and contractures to extremities. This focus area was initiated on 1/31/17 and most recently reviewed on 1/31/18.

An observation was conducted of the dinner meal on the 700 Hall on 1/28/18 at 5:48 PM. Social Worker (SW) #1 served a meal tray to Resident #10 in her room. The tray was left covered and set up was not provided by SW #1. As SW #1 exited the room he stated, "she ' s a feeder", indicating that a staff member was going to assist Resident #10 with eating.

An interview was conducted with Resident #10 on 1/29/18 at 10:02 AM. Resident #10 was in bed in her room. She was alert and oriented to self, but was unable to answer open ended questions logically.

An interview was conducted with Nurse Unit Manager (UM) #1 on 1/31/18 at 10:25 AM. Nurse UM #1 stated that it was not appropriate to use the term "feeder" to describe a resident who required assistance with eating. She explained that this was a dignity concern. She reported if she heard a staff member call a resident a "feeder" she would ask the staff member to instead say that the resident required assistance with eating.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 6 An interview was conducted with SW #1 on 1/31/18 at 10:30 AM. SW #1 stated he had worked at the facility for about 8 months. He indicated he sometimes assisted staff by passing out trays on the halls during meal times. SW #1 was asked how he knew if a resident required assistance with eating. He stated he knew who "the feeders" were. He confirmed he was passing meal trays on the 700 Hall on 1/28/18 for the dinner meal. The event on 1/28/18 at 5:48 PM in which he was observed serving Resident #10 ' s meal in her room and upon exiting her room stating, "she ' s a feeder" was reviewed with SW #1. SW #1 stated he had not recalled making that statement as he exited Resident #10 ' s room. An interview was conducted with the Social Services Director on 1/31/18 at 10:33 AM. She stated she expected staff not to utilize labels for residents such as "feeder". She indicated staff were to say a resident required assistance with eating. An interview was conducted with the Director of Nursing on 2/1/18 at 12:25 PM. She stated it was her expectation that staff never utilize labels such as "feeder" to describe a resident. She indicated staff were to say a resident required assistance with eating.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 7 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observations and resident, staff and family interviews, the facility failed to honor the resident ' s preference to communicate in Spanish resulting in the staff ' s inability to assess him and determine his needs. This was evidenced by 1 of 1 residents reviewed for communication/sensory (Resident #3). Findings included: Resident # 3 was admitted to the facility on 1/28/17 with diagnoses including Anxiety, Depression, history of fall, and Contracture of Muscle Unspecified site.	F 561	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F561 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 8 Resident #3 ' s annual Minimum Data Set dated 1/5/18 revealed the resident was severely cognitively impaired, had no behaviors, required extensive assistance of 2 persons for transfer, 1 person for activities of daily living/personal care, and set up for meals. Resident #3 ' s care plan dated 1/22/18 revealed he had a communication deficit related to a language barrier. The resident was Spanish speaking and spoke very little English. The resident preferred to communicate in Spanish. The intervention indicated the resident will restore communication losses and communication with others, understanding others/being understood while engaging in every day decision making. A Spanish speaking staff member was to be used to interpret. The call light was to be in reach. The staff was to observe for physical/nonverbal indicator of discomfort or distress and follow up as needed. On 1/28/18 at 9:30 am an observation was done of Resident #3. The resident was in his bed. The resident was motioning and speaking in Spanish for assistance to reach his breakfast. The call light was on the floor. The resident's hair appeared dirty and his nails were long. The resident was pulling on his sheet and saying "hace frio" (it's cold). There was no communication board or care plan/Kardex identified in the room. The resident was rubbing his hair and pointing to his long fingernails while speaking in Spanish. On 1/29/18 at 10:00 am an interview was conducted with Nursing Assistant (NA) #3. NA #3 stated that she partially understood Resident #3's	F 561	a)Staff re-education given by SDC (Staff Development Coordinator) and/or DON and/or ADON on honoring residents communication preferences by March 2, 2018. It is alleged the facility failed to honor the residents preference to communicate in Spanish resulting in the staffs inability to assess him and determine his needs (Resident #3). 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)100% audit completed on 1/28/18 with no other residents identified as having a preference to communicate in another language. b)Communication boards replaced in bedside drawer and in residents closet on 1/28/18. c)On 1/28/18 Resident nails cut, shower given, dental care setup was provided, and heater knob replaced by maintenance. d)On 1/29/18 all present staff to include PRN, weekend, and agency were re-educated by ADON and/or Unit Coordinators on using the toll free interpreting services. A sticker was placed in resident chart and a flyer for the services was placed inside residents closet. e)On 1/29/18 Residents care-plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 9 communication. NA #3 stated that she does not use an interpreter or a communication board because she feels she can understand the resident ' s personal care needs. NA #3 stated that she provided the resident a bed bath and he had not received personal care yet this morning. NA #3 did not comment about the resident ' s long fingernails, but commented that the resident can brush his own teeth with set up. On 1/29/18 at 10:00 am an observation was done of Resident #3 and NA #3. The resident informed NA #3 in Spanish that he was cold and wanted his pants. NA #3 stated she did not understand the resident and did not seek interpretation at this time. The surveyor interpreted. The resident appeared anxious and stated "daughter." NA #3 obtained the cordless phone and called the resident ' s daughter. NA #3 did not speak to the resident ' s daughter. The resident spoke to his daughter in Spanish and appeared more relaxed. On 1/29/18 at 10:10 am an interview was conducted in Spanish with Resident #3 using a translator, an employee of the facility housekeeper #1. The resident stated that he had not had a shower for 2 weeks, only a bed bath. His hair had not been washed. The resident desired a shower. The resident stated he needed help with teeth brushing and had not received help for the past 8 days. The resident stated that he was not provided incontinence care all night and tried to get staff ' s attention. The resident stated he was cold and had no blanket. The resident stated during his bed bath NA #3 asked him if his teeth were brushed this morning. The resident informed NA #3 no, but she did not brush the resident's teeth. The resident stated that his stomach hurt and that he thought he needed to	F 561	updated to reflect for staff to use interpreting services and/or communication board. f)During orientation of newly hired staff, education will be provided regarding honoring residents□ communication preferences. g)When a resident whose predominate language is other than English is admitted to the center, the resident and or responsible party will be asked what language the resident prefers to communicate and the resident□s preference will be care planned and honored. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies sited remains corrected and/or in compliance with the regulatory requirements. a)Observation audits will be performed 5 times weekly X 12 weeks to validate resident preference are honored. The audits will be completed by DON and/or Unit coordinators. b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Performance Improvement Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 10 have a bowel movement. During interpretation Nurse #3 entered the room to provide the resident medications. The resident was lying flat. Nurse #3 informed the resident in English that he had medication and was going to raise the head of the bed (HOB). The HOB was raised about 40%. The resident requested in Spanish the HOB be raised higher and Nurse #3 did not understand and tried to hand the resident the medication and water, but the resident refused. The request was interpreted by the interpreter and Nurse #3 raised the HOB more after being informed and the resident took his medication. The resident stated that staff does not understand him. An interview was conducted on 1/29/18 at 11:00 am with Nurse #3. Nurse #3 stated that he had worked at the facility about two months. Nurse #3 stated that he anticipated Resident #3 ' s needs, does not speak Spanish and had not used an interpreter. Nurse #3 stated that a couple of the housekeeping staff speak Spanish and are available. Nurse #3 was not aware of the interpretation service. On 1/29/18 at 10:49 am an interview was conducted with the Director of Nursing (DON). The DON was informed by the surveyor of Resident #3's concerns and DON replied that she was not aware. The DON stated she thought there was a communication board in the resident ' s room. The DON also stated that the facility staff had access to an interpreting service by telephone and know how to use it. A review of Resident #3 ' s care plan updated 1/29/18 revealed there was an added intervention for staff to use the interpreter service for interpretation and how to use the service.	F 561	implementing the acceptable POC. a)The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 11 On 1/31/18 at 9:30 am an interview was conducted with Resident #3's daughter. The daughter stated that the resident spoke very little English and would not be able to provide any detail in English if there was something wrong or if the resident needed something. The daughter believed that the staff anticipated usual daily needs, but the communication was limited. The daughter stated that the facility had not called her to interpret. The daughter stated that the resident called the family when he was distressed. The daughter stated that she was informed by the resident that the staff does not understand him. On 2/1/18 at 9:45 am an interview was conducted with Social Work (SW) #1. SW #1 stated that Resident #3's care plan had the intervention that "the resident will restore communication losses and communicate with others." SW #1 stated the meaning was when the resident spoke Spanish and the staff did not understand the staff will ask the resident to speak English. SW #1 stated that he agreed the resident can speak very little English and that the resident required Spanish language communication to understand open-ended questions. SW #1 stated that the resident's care plan indicated the resident preferred to communicate in Spanish. On 2/1/18 at 9:50 am an interview was conducted with Social Work (SW) #2 and she stated that an interpreter was required when she completed Resident #3's assessment.	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment.	F 584		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 12	F 584		

The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations and interview of the residents and staff and record review, the facility failed to provide a clean bathroom without odor for 3 of 6 bathrooms observed during a review of the environment (Rooms #625, #627, and #632). Findings included: On 1/28/18 at 4:40 pm an observation was done of Room #632 ' s bathroom. The bathroom had strong odor of what smelled like stool and urine. The area around the toilet base was missing the flooring and was black in color. The floor was wet. The toilet seat and down the outside of the toilet bowl had a moderate amount of brown matter which looked like stool. There was also a small amount of brown matter on the resident ' s bathroom and room floor. On 1/28/18 at 4:40 pm an interview was conducted with Resident #76 who lived in room #632. Resident #76 had an intact cognition. Resident #76 stated that he smelled the foul bathroom odor. The resident stated that he had informed staff on more than one occasion that his bathroom needed cleaning. The bathroom was shared by four residents and never stayed clean. Resident #76 was interviewed on 1/30/18 at 9:14 am and stated he was continent of bowel and bladder. The resident stated he can smell a foul odor coming from the bathroom and thought the bathroom had not been cleaned. On 1/28/18 at 5:45 pm an observation was done of Room #632 ' s bathroom. The bathroom was in the same condition as was earlier in the day at	F 584	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F584 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)On February 1, 2018 Housekeeping Supervisor educated by Administrator on expectations for services necessary to maintain a sanitary, orderly, and comfortable interior. On February 1, 2018 Housekeeping Supervisor provided one to one re-education to the Housekeeper assigned to rooms 625, 627 and 632 on expectations for services necessary to maintain a sanitary, orderly, and comfortable interior. On February 2, 2018 Housekeeping Supervisor re-educated all housekeeping staff on expectations for services necessary to maintain a sanitary, orderly, and comfortable interior. It is alleged the facility failed to provide a clean bathroom without odor for 3 bathrooms observed during environmental review (Rooms 625, 627, and 632). Bathrooms in rooms 625, 627 and 632 were cleaned on Feb 1, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 14 4:30 pm. On 1/29/18 at 12:00 pm an observation was done of Room #632 ' s bathroom. The bathroom was in the same condition as was found on 1/28/18 at 4:40 pm. On 1/29/18 at 5:45 pm an observation was done of Room #632 ' s bathroom. The bathroom was in the same condition and odor as was observed on 1/28/18 at 4:40 pm. The brown matter on the toilet seat and bowl now appeared dry. On 01/30/18 at 9:14 am an observation was done of Room #632 ' s bathroom. The bathroom was cleaned of stool from the outside of the toilet bowl and the floor. The ring around the base of the toilet was in the same condition and the odor was unchanged as was found on 1/28/18 at 4:40 pm in the bathroom and resident ' s room. On 1/31/18 at 5:15 pm an observation was done of Room #632 ' s bathroom. The floor and odor remained the same as the observation of 01/30/18 at 9:14 am. On 2/1/18 at 9:45 am an observation was done of Room #632 ' s bathroom. The floor and odor remained the same as the observation of 01/30/18 at 9:14 am. On 1/29/18 at 9:30 am an observation was done of Room #625 ' s bathroom. The bathroom had a moderate odor of what smelled like mold and urine. The floor around the toilet was wet and had a yellow and orange discoloration. The base of the toilet was soiled with ring of brown matter. On 1/29/18 at 12:30 pm an observation was done	F 584	2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)On February 1, 2018 Housekeeping Supervisor educated by Administrator on expectations for services necessary to maintain a sanitary, orderly, and comfortable interior. b)On February 2, 2018 Housekeeping Supervisor re-educated all housekeeping staff on expectations for services necessary to maintain a sanitary, orderly, and comfortable interior. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Administrator and/or Housekeeping Supervisor to randomly round on five resident bathrooms to include all halls 3 times weekly X 12 weeks, to include weekends, to validate bathrooms are maintained in a sanitary, orderly, and comfortable interior. b)The Administrator and/or Housekeeping Supervisor will report findings of audits monthly to the Quality Assurance Performance Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 15 of Room #625 ' s bathroom. The bathroom was in the same condition and odor as was observed earlier in the day at 9:30 am. The housekeeper was observed to enter the room, observe the bathroom, empty the garbage, and leave. On 1/29/18 at 10:30 am an observation was done of Room #627 ' s bathroom with Nurse #3. The bathroom had a very strong odor of what resembled urine. The floor around the toilet base was wet, crusty and appeared dark yellow. The inside rim of the toilet had small, multiple brown areas of what appeared to be dried stool. On 1/29/18 at 10:35 am an interview was conducted with Resident #51 who lived in room #627. Resident #51 had an intact cognition and stated that the bathroom was filthy and had an odor. Resident #51 stated that he did not want to use that bathroom anymore and felt angry. Resident #51 stated that he had informed the staff about the bathroom ' s condition numerous times without any change. On 1/30/18 at 11:45 am an interview was conducted with Nurse #3. Nurse #3 stated that each bathroom was shared by 4 residents. Nurse #3 was made aware by Resident #51 that his bathroom was dirty every day because two of the residents that shared the bathroom made a mess. Nurse #3 stated on 1/30/18 at 10:30 am he observed the bathroom was dirty with what resembled urine on the floor and what resembled stool on the sides of the toilet bowel and had an odor of urine. Nurse #3 stated that no other staff had informed him of the bathroom condition in Room #627. Nurse #3 stated he would have housekeeping clean the bathrooms.	F 584	implementing the acceptable POC. a)Administrator and/or Housekeeping Supervisor be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 16 On 1/29/18 at 10:45 am an interview was conducted with Resident #15 who lived in room #627 and had an intact cognition. Resident #15 stated the bathroom was frequently dirty and had an unpleasant odor. Resident #15 also stated that staff had been made aware on more than one occasion. On 1/29/18 at 4:30 pm an observation was done of Room #627 ' s bathroom. The bathroom was in the same condition and odor as was observed earlier in the day at 10:30 am. On 1/29/18 at 5:20 pm an observation was done of Room #627 ' s bathroom. The bathroom floor was dry and had the same yellow ring at the base of the toilet and the odor was unchanged from 1/29/18 at 10:30 am.	F 584		
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, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Residents #98 and #128) and behaviors (Residents #9 and #57) for 4 of 35 residents reviewed. The findings included: 1. Resident #98 was admitted to the facility on 7/2/09 and most recently readmitted on 6/9/17 with diagnoses that included cerebral palsy and seizure disorder.	F 641	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F 641 1.The plan of correcting the specific	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 17 The quarterly MDS assessment dated 1/9/18 indicated Resident #98 rarely/never understood and rarely/never understands. He was assessed with short-term and long-term memory problems and severely impaired decision making. Resident #98 was dependent on 2 or more staff with transfers and bathing. He was dependent on 1 staff with bed mobility, locomotion on/off the unit, dressing, eating, toileting, and personal hygiene. Resident #98 was assessed with impairment on both sides of his upper and lower extremities. He had no falls noted and no physical restraints (defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily which restricts freedom of movement or normal access to one ' s body). A Bed Rail Safety Review assessment was completed for Resident #98 on 1/27/18. Resident #98 was assessed as non-ambulatory, unable to communicate his needs, unable to get in/out of bed independently, unable to reposition himself in bed independently, and he exhibited problems with balance and/or trunk controls. Resident #98 was noted as having uncontrolled or involuntary movements described as moving his hands and hitting the side of the bed rails while in bed. This Bed Rail Safety Review indicated Resident #98 ' s Responsible Party (RP) expressed a desire to have bed rails for safety. It additionally indicated that no alternatives to bed rails were attempted due to the RP ' s preference to utilize the bed rails. The use of bilateral full-length bed rails was noted to be continued. This form was signed by Nurse Unit Manager (UM) #1 on 1/28/18. An observation was conducted of Resident #98 in	F 641	deficiency. The plan should address the process that lead to the deficiency. a)The Resident Care Management Director (RCMD) or Minimum Data Set (MDS) Coordinator will complete an audit, to be completed by March 2, 2018 of current residents receiving an Omnibus Budget Reconciliation Act Assessment during the last seven days to verify accurate coding of Sections E and P of the Minimum Data Set (MDS) per the Resident Assessment Instrument (RAI) Manual guidelines. If needed, modifications will be completed by the RCMD and/or MDS Coordinator per the RAI Manual guidelines Resident #98 had modification of section P to reflect the bed rails for Assessment Reference Date 1/9/18. Resident#128 had a modification of section P for bed rail use for Assessment Reference Date 1/2/18. Resident #57 had a modification of section E for Assessment Reference Dates 10/20/17 and 11/7/17 to reflect the resident□s refusals of care. Resident #9 had a modification of section E for Assessment Reference Date 1/10/18 to reflect the resident□s refusals of care. The process breakdown occurred when the coding of the Minimum Data Assessments did not correspond with the Resident Assessment Instrument Manual. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)District Director Care Management will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 18 bed on 1/28/18 at 4:16 PM. The bed had bilateral full-length bed rails with full-length pads. An interview was conducted with Nursing Assistant (NA) #6 on 1/31/18 at 4:15 PM. She stated she had worked at the facility for 2 years and had worked with Resident #98 during that entire length of time. She indicated Resident #98 was alert, not oriented, and non-verbal. She stated Resident #98 moved around a lot in bed if he was agitated or needed something such as incontinent care. She reported it was this body language that helped to let the staff know if he needed something. NA #6 stated Resident #98 was minimally able to follow direction when he was being repositioned or provided with care. She reported he was dependent on staff for Activities of Daily Living (ADLs). She indicated Resident #98 also had uncontrolled body movements at times. She reported he was a fall risk and had bilateral full-length bed rails with full-length pads. She stated the bilateral full-length bed rails had been in use for Resident #98 since she began working with him 2 years ago. She reported sometimes Resident #98 removed the pads from the bed rails and the staff had to put them back in place. NA #6 indicated she believed the bilateral full-length bed rails were in place to prevent Resident #98 from rolling off the bed. An interview was conducted with Nurse UM #1 on 1/31/18 at 4:30 PM. She indicated Resident #98 had agitation at times that was exhibited by yelling out nonsensical words and/or uncontrolled movements. She stated when Resident #98 was agitated while in bed he was able to position himself against the bed rails. She reported Resident #98 was a fall risk. She explained that	F 641	provide education to the Interdisciplinary Team members who participate in MDS coding of sections P and E related to accurate coding of MDS according to the RAI Manual on March 2, 2018. The RCMD will randomly audit five completed MDSs weekly for 12 weeks and then five random MDSs monthly for 9 months to verify accurate coding of Sections P and E of the MDS. One to one education will be provided if opportunities for corrections are as identified as a result of these audits. Modifications to the MDS will be completed as needed. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The results of these audits will be presented by the Resident Care Management Director monthly for 12 months at Facility Quality Assurance Performance Improvement (QAPI) Committee Meeting. The QAPI Committee will make changes or recommendations as indicated. 4.Title of person responsible for implementing the acceptable POC. a)The Resident Care Management Director is responsible for implementing and sustaining the plan of correction. 5.Dates when corrective action will be completed. The corrective action dates	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 19	F 641		

sometimes when she entered his room in the morning half of his body was positioned up against the bed rail. She explained that if the bed rail was not in place Resident #98 would have fallen out of bed. Nurse UM #1 indicated the pads were added to the bilateral full-length bed rails so Resident #98 ' s skin integrity was not impaired by the bed rails when he positioned himself against them or as a result of hitting the rails during a seizure.

An observation was conducted of Resident #98 in bed on 2/1/18 at 8:10 AM. The bed had bilateral full-length bed rails with full-length pads.

An interview was conducted with the MDS Coordinator on 2/1/18 at 10:30 AM. The MDS Coordinator was asked what information she utilized to code the MDS for physical restraints. She stated this facility had been restraint free for years. She indicated, for the purpose of coding the MDS, she observed the resident to see if there was any type of typical physical restraint in use, such as anything that would block the resident from doing something that they wanted to do. She stated if a resident was dependent on staff for transfers and bed mobility then a bed rail was not going to block the resident from doing something they wanted to do.

This interview with the MDS Coordinator continued. The MDS assessment dated 1/9/18 that indicated Resident #98 had no physical restraints was reviewed with the MDS Coordinator. She verified she completed this section of Resident #98 ' s 1/9/18 MDS assessment. She was asked to describe the assessment process she used to code this assessment for no physical restraints. The MDS

must be acceptable to the State.

a)March 2, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 20	F 641		

Coordinator reported she observed Resident #98 and noted he had bilateral half-length bed rails. She indicated he had those bed rails for safety related to the medical symptom of a seizure. She explained that if Resident #98 had a seizure he had the potential to roll out of bed. She stated Resident #98 had very little body movement. She reported she also asked staff if Resident #98 needed assistance with turning and repositioning him and they indicated he required their assistance. The MDS Coordinator stated she was unaware Resident #98 had bilateral full-length bed rails with full length pads.

An interview was conducted with the Director of Nursing (DON) on 2/1/18 at 12:25 PM. She stated she expected the MDS to be coded accurately and for physical restraints to be coded if they were in use. She reported the facility had not utilized physical restraints and therefore had not completed restraint assessments. The DON indicated Resident #98 ' s bilateral full-length bed rails were in place related to his seizures. She explained that the bed rails prevented Resident #98 from falling out of bed as result of a seizure. She stated Resident #98 ' s family was insistent on having the full-length bed rails for his safety.

2.
Resident #128 was admitted to the facility on 2/2/2007.

Resident #128 's quarterly Minimum Data Set (MDS) dated 1/2/18, revealed it was coded in Section P., Physical restraints was coded as (H) for other and restraint used less than daily. The resident was moderately cognitively impaired.

A review of the 12/25/17 to 1/2/18 nurses ' notes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 21	F 641		

revealed the resident was not documented as having had restraints.

On 1/29/18 at 11:30 am an interview was conducted with Resident #128. The resident was unable to answer whether he had restraints during the MDS quarterly look-back-period.

On 01/30/18 at 3:37 pm an interview was conducted with the Minimum Data Set (MDS) Coordinator #1. MDS Coordinator #1 stated that Resident #128's quarterly MDS dated 1/2/18 was incorrectly coded Section P. (H) for "restraints: other, not used every day" and would be corrected. The resident did not have restraints.
3. a. Resident #57 was admitted to the facility on 8/10/17. Cumulative diagnoses included major depressive disorder and bipolar disease.

A Significant Change Minimum Data Set (MDS) dated 10/20/17 indicated Resident #57 was cognitively intact. No behaviors were noted as having occurred during the seven day look back period (10/14/17-10/20/17).

A review of Resident #57 ' s nursing notes revealed the following:
A nursing note dated 10/14/17 at 6:52 AM stated Resident #57 kept turning on the wound vac (machine used to aid in pressure ulcer healing) and stated he was not going to listen to that.

A nursing note dated 10/14/17 at 11:14AM stated Resident #57 refused to have wound vac reapplied and refused to have dressing change completed. Resident stated he was going to get up and was not going to get the wound vac on because it was not helping.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 22	F 641		

A nursing note dated 10/15/17 at 11:02 AM stated Resident #57 refused to have wound vac reapplied stating he was not going through that again and he did not want the smell of that wound vac anymore. Resident #57 was asked if staff could do a dressing change and he stated no. It was done last night and he would let them know when he wanted to have the dressing change done.

A nursing note dated 10/16/17 at 10:34 AM stated Resident #57 refused wound vac treatment.

A nursing note dated 10/17/17 at 5:55 PM revealed Resident #57 continued to be non-compliant with repositioning during the day.

A nursing note dated 10/17/17 at 6:12 PM stated Resident #57 had physician orders to turn and reposition every two hours for unstageable wounds. Resident #57 was out of bed in his wheelchair and refused repositioning in chair.

A nursing note dated 10/18/17 at 12:38 AM stated Resident #57 continued to refuse repositioning by staff.

A nursing note dated 10/18/17 at 9:05 AM said the nurse offered to reposition resident while she was in his room giving his morning medications. Resident #57 declined and stated he was fine the way he was and he wished people would stop asking him to turn.

A nursing notes dated 10/19/17 at 6:35 AM revealed Resident #57 refused turning and repositioning.

A Social Services Note dated 10/19/17 at 4:28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 23	F 641		

PM stated Resident #57 was cognitively intact. A review of nurses ' notes revealed he was non-compliant with care.

A nursing note dated 10/20/17 at 3:10 PM stated turn and reposition every 2 hours for unstageable wounds. Resident refused.

3. b. Resident #57 was admitted to the facility on 8/10/17. Cumulative diagnoses included major depressive disorder and bipolar disease.

A Quarterly MDS dated 11/7/17 indicated Resident #57 was cognitively intact. No behaviors were noted for the seven day look back period (11/1/17-11/7/17).

A review of the nursing notes revealed the following:

A nursing note dated 11/1/17 at 6:42 AM stated turn and reposition every 2 hours for unstageable wounds. Resident #57 refused.

A nursing note dated 11/2/17 at 3:00 AM stated Resident #57 refused turning and repositioning.

A nursing note dated 11/3/17 at 5:36 AM stated Resident #57 refused turning and repositioning and stated that he wanted to be left alone.

A nursing note dated 11/3/17 at 9:45 PM stated Resident #57 refused turning.

A nursing note dated 11/4/17 at 5:21 AM stated Resident #57 refused turning and repositioning and stated he could turn himself.

A nursing note dated 11/5/17 at 8:48 PM stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 24	F 641		

Resident #57 was reported by visitors that he was smoking out front in the front parking lot. Nurse advised Resident #57 that he could not smoke in non-designated smoke areas. Resident was not receptive to verbal education. He began using profanity towards the nurse yelling and sticking his middle finger up saying educate this.

A nursing note dated 11/5/17 at 9:06 PM stated Resident #57 continued to refuse to be turned and repositioned. Resident also refused to lay in bed and get off his wounds.

A review of Medication Administration Record for November revealed Resident refused turning and reposition daily from 11/1/17 through 11/7/17.

On 1/31/18 at 3:05 PM, an interview was conducted with the Social Services Director. She stated she reviewed nursing notes, behavior notes and spoke with staff prior to completing section E for behaviors. She stated she had completed the behavior section for Resident #57 on 10/20/17 and 11/7/17. She reviewed the information and stated she should have coded the refusal of care on the MDS (daily) on both MDS assessments and should have coded refusal of care and verbal behavioral symptoms on the MDS dated 11/7/17.

On 2/1/18 at 12:25 PM, an interview was conducted with the Director of Nursing who stated she expected the MDS to be coded accurately.

4. Resident # 9 was admitted to the facility on 4/25/16 with multiple diagnoses including dementia with behavioral disturbances and anxiety disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 25	F 641		

The quarterly Minimum Data Set (MDS) assessment dated 1/10/18 indicated that Resident #9 had severe cognitive impairment and received an antipsychotic, and antianxiety medications. The assessment also indicated that Resident #9 did not have any behavior of rejection of care including taking of medication.

Resident #9's nurse's notes were reviewed. The notes dated 1/5/18 at 9:45 AM, 1/8/18 at 12:01 PM, and 4:40 PM, and on 1/9/18 at 10:13 AM and 1:15 PM revealed that Resident #9 had refused medications.

Resident #9's Medication Administration Records (MARs) for January 2018 were reviewed. The MARs revealed that Resident #9 had refused to take her medications including Depakote (used to treat behaviors), Metoprolol and Cardizem (used to treat hypertension), Spiriva (used to treat asthma) and Potassium Chloride (used to treat low Potassium level) at 9:00 AM on 1/4/18, 1/5/18, 1/9/18 and 1/10/18. The MARs also indicated that Resident #9 had refused to take her Lantus (used to treat Diabetes Mellitus) and Sertraline (used to treat depression) at 9:00 on 1/4/18, 1/5 18 and 1/9/18.

On 1/31/18 at 2:43 PM, Nurse #5 (assigned to care for Resident #9) was interviewed. Nurse #5 stated she was responsible for administering Resident #9's medications during the 7:00 AM to 3:00 PM shift. Nurse #5 acknowledged that Resident #9 had been refusing to take her medications.

On 1/31/18 at 3:33 PM, Social Worker #2 was interviewed. She stated that she was responsible for completing section E (behavior) on the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 26 assessment. She stated that she did not accurately code the behavior of rejection of care on Resident #9's quarterly MDS assessment dated 1/10/18 based on the resident refusing to take her medications. On 2/1/18 at 12:22 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS assessments to be accurate. The DON agreed that Resident #9's quarterly MDS of 1/10/18 should have been coded for rejection of care under behavior.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interview, the facility failed to involve the resident's representative in the care planning process for 2 of 2 sampled residents reviewed (Residents # 44 & #98). Findings included: 1. Resident #44 was admitted to the facility on 5/4/15 with multiple diagnoses including dementia. The significant change in status Minimum Data Set (MDS) assessment dated 10/31/17 indicated that Resident #44 had severe cognitive impairment. Review of the interdisciplinary care conference attendance record revealed that Resident #44 had a care plan meeting on May 3, 2017 and August 22, 2017. The record did not indicate that the family/ resident representative had attended the meeting on both dates. The record also did not indicate that a care plan meeting was held after August 2017. On 1/29/18 at 12:46 PM, a family member of Resident #44 was interviewed. The family member stated that she had not been invited to a care plan meeting. The family member was the resident's emergency contact, and had signed the admission paper for Resident #44 and thereby was the resident's representative. Resident #44's social services notes were reviewed. The notes dated 4/25/17, 9/26/17, 10/31/17 and 1/31/18 did not indicate that the	F 657	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F657 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Staff education provided by Administrator on February 5, 2018 to Social Workers on the requirements for the care planning process including maintaining a copy of the invitation letter to attend the care plan meeting. It is alleged the facility failed to involve the resident□s representative in the care planning process for 2 of 2 sample residents reviewed (Resident #44 and #98). 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Administrator provided education to the Social Workers on the requirements for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28 resident's representative was involved in the care planning process. The notes also did not indicate that a follow up call was made/attempted to contact resident's representative regarding the care planning process. There was no documentation of the reason as to why the resident's representative was not participating in the care planning process or the steps taken by the facility to include the resident's representative in the process. On 2/1/18 at 8:59 AM, Social Worker (SW) #2 was interviewed. She stated that the MDS Nurse made the list of residents for care planning. The SW was then responsible for sending an invitation letter to the resident's representative by mail. The SW provided 2 letters (May 10, 2017 and August 22, 2017) but the letters did not have a date when they were mailed to the resident's representative. The SW was unable to provide an invitation letter after August 2017. On 2/1/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the care plan meeting to be held every 3 months and the residents or resident's representative should be involved in the care plan meeting every 3 months. 2. Resident #98 was admitted to the facility on 7/2/09 and most recently readmitted on 6/9/17 with diagnoses that included cerebral palsy. The annual Minimum Data Set (MDS) assessment dated 12/14/17 indicated Resident #98 was rarely/never understood and rarely/never understands. He was assessed with short-term and long-term memory problems and severely impaired decision making.	F 657	the care planning process including maintaining a copy of the invitation letter to attend the care plan meeting. These copies will be filed by Director of Social Services and/or Social Worker and maintained in a binder, located in the Director of Social Services' office. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The Director of Social Services will randomly review five care planning invitations weekly X 12 weeks to validate requirements are being met. b)The Director of Social Services will report findings of audits monthly to the Quality Assurance Performance Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)The Director of Social Services is responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29	F 657		

A review of the record revealed the most recent care plan meeting invitation was sent to Resident #98 ' s Responsible Party (RP) for a meeting on 8/17/17.

An interdisciplinary care conference attendance record dated 8/17/17 was signed by the MDS Coordinator, Dietary Manager, Social Worker (SW) #1, and the Activities Director. No additional attendees were noted. The form asked if the resident attended and if the RP attended. Both of these questions were unanswered. There was no additional information documented for this care plan meeting on 8/17/17. There was no evidence in the medical record of any care plan meeting for Resident #98 since 8/17/17.

An interview was conducted with Resident #98 ' s RP on 1/28/18 at 4:16 PM. She indicated the facility utilized care plan meetings to involve her in the care planning process. She reported she received invitations for care plan meetings so she knew when they were scheduled and the last invitation she received was about 6 months ago.

An interview was conducted with the MDS Coordinator on 2/1/18 at 8:11 AM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She stated the MDS Nurses and Social Workers shared the responsibilities of conducting the care plan meetings.

An interview was conducted with SW #2 on 2/1/18 at 8:59 AM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She stated the MDS nursing staff made a list of residents for care plan meetings and the SWs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30 were responsible for mailing invitations to the RP. An interview was conducted with the Social Services Director on 2/1/18 at 11:00 AM. She was unable to provide evidence of any care plan meeting invitations sent to Resident #98 ' s RP after 8/17/17. She was also unable to provide evidence of a care plan meeting being conducted for Resident #98 after 8/17/17. The Social Services Director was unable to explain why a care plan meeting had not been held for Resident #98 since 8/17/17. An interview was conducted with the Director of Nursing (DON) on 2/1/18 at 12:25 PM. She indicated the facility utilized care plan meetings to involve the resident and/or RP in the care planning process. She reported her expectation was for a care plan meeting to be held every 3 months and for the resident and/or RP to be invited to each meeting.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide incontinent care and nail care upon request for 2 of 4 sampled residents reviewed for activities of daily living (ADL)(Residents # 9 & #111). Findings included: 1. Resident #9 was admitted to the facility on	F 677	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law.	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 31 4/25/16 with multiple diagnoses including dementia with behavioral disturbances. The quarterly Minimum Data Set (MDS) assessment dated 1/10/18 indicated that Resident # 9 had severe cognitive impairment and she needed extensive assistance with toilet use and personal hygiene. The assessment also indicated that Resident #9 was frequently incontinent of bowel and bladder. Resident #9's care plan dated 1/28/18 was reviewed. One of the care plan problems was requiring staff assistance for completion of activities of daily living (ADL) needs. The goal was her ADL needs will be identified and met with staff assistance. The approaches included to clean peri area with each incontinent episode. On 1/29/18 at 9:01 AM and 10:30 AM, Resident #9 was observed in bed, positioned on her right side. She was observed lying on a pad that was soiled with dried feces and with a round brown ring. On 1/29/18 at 10:45 AM, NA (Nurse Aide) #5 was observed to enter the room of Resident #9. When interviewed, she stated that she was ready to provide AM care and to check her for incontinence. NA #5 was observed to provide AM care to the resident. Resident #9 was observed to have dried feces and urine on her disposable brief. On 1/29/18 at 10:50 AM, NA #5 was interviewed. She stated that she didn't have time to check Resident #9 before breakfast. NA #5 indicated that the breakfast trays came at 7 AM and she tried to take care of other residents first. She admitted that she didn't check Resident #9 since	F 677	F677 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)NA #7 and NA#5 were provided one to one re-education on providing timely activities of daily living care (ADL) by Staff Development Coordinator on February 1, 2018. It is alleged that the facility failed to provide incontinent care and nail care upon request for 2 of 4 sampled residents reviewed (Residents #9 and #111). 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Certified Nursing staff will be re-educated to include, PRN and weekend staff, on providing timely ADL care by Staff Development Coordinator and/or ADON to be completed by March 2, 2018. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Observation audits will be performed 5 times weekly X 12 weeks, to include all shifts and weekends, to validate resident are receiving timely and proper assistance with activities of daily living. The audits will be completed by DON and/or Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 32 7 AM. On 2/1/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected NAs to check residents before breakfast and to provide timely incontinent care. 2. Resident #111 was admitted to the facility 5/3/14. Cumulative diagnoses included hemiplegia and hemiparesis following a cerebrovascular accident (CVA). A Quarterly Minimum Data Set (MDS) dated 12/20/17 indicated Resident #111 was cognitively intact. She required extensive assistance with personal hygiene. A care plan dated 10/24/17 and last reviewed 1/29/18 stated Resident #111 needed extensive assistance with personal hygiene and oral care. On 1/29/18 at 11:11 AM, an observation of Resident #111's hands revealed all of her fingernails on both hands were approximately 3/4 to 1 inch long with black/ brown material under all the nails. Resident #111 stated the fingernails were too long and she liked them short and clean. She said she had asked someone to cut her nails on 1/28/18 but no one had cut them. She could not remember exactly who she had asked to cut her fingernails. On 1/30/18 at 11:36 AM, a second observation of Resident #111's fingernails was conducted. The fingernails remained elongated with black/ brown material under her nails. On 1/31/18 at 8:45 AM, morning care was observed with NA #7. An observation of Resident #111's fingernails revealed the nails had been	F 677	coordinators. b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Performance Improvement Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33 cleaned under each nail but the fingernails remained elongated and had not been trimmed. NA#7 stated it had been documented that Resident #111 had received a bath by night shift. When asked what was done during morning care, she stated morning care was washing the body, mouth care, combing hair, and cleaning fingernails. She stated the nursing assistants could cut Resident #111's fingernails. She observed Resident #111's fingernails and stated they should have been cut. On 1/31/18 at 9:40 AM, Resident #111's fingernails were observed with the Director of Nursing. She stated part of the morning care consisted of observing and cleaning and cutting fingernails as needed. She said Resident #111 was alert and able to communicate her needs and therefore, when she asked to have her nails cut on Sunday, nursing staff should have cut her fingernails as requested.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility	F 688		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 34 receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interview, the facility failed to provide treatment to prevent further decrease in range of motion for 1 of 4 sampled residents reviewed for range of motion (Resident #75). Findings included: Resident #75 was admitted to the facility on 7/5/07 with multiple diagnoses including multiple sclerosis and paraplegia. The quarterly Minimum Data Set (MDS) assessment dated 1/12/18 indicated that Resident #75's cognition was intact and he had limitation in range of motion on one side of upper extremity. The assessment also indicated that he was not receiving restorative nursing program. Resident #75's care plan dated 1/28/18 was reviewed. One of the care plan problems specified the resident had multiple sclerosis and paraplegia affecting his right upper extremity and both lower extremities. The goal was to remain free of complications or discomfort related to multiple sclerosis and paraplegia. The approaches included physical therapy (PT), occupational therapy (OT) and speech therapy (ST) to evaluate and treat as ordered. The OT notes dated 12/6/16 revealed that Resident #75's right upper extremity was impaired and his right hand was in fist like position.	F 688	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F688 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)It is alleged the facility failed to provide treatment to prevent further decrease in range of motion (Resident #75) due to therapy not communicating the need of a right hand palm guard. The breakdown in the process occurred when the resident was discharged from therapy and there was no communication to the nursing staff on the need for the right palm guard. On February 1, 2018 Rehab Program Manager educated therapy staff on expectations for services necessary to maintain range of motion and/or to prevent further decrease in range of motion and communication of recommendations using a Restorative Referral Sheet. On February 1, 2018 Rehab Program Manager provided one to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 35 The OT notes dated 9/21/17 revealed that OT evaluated Resident #75 and his long term goal was to wear right hand palmar guard for 6 hours with no negative skin changes nor complain of pain or discomfort. OT dates of service were 9/21/17 - 12/19/17. On 1/29/18 at 4:39 PM, Resident #75 was observed in bed with right hand in a fist position. There was no splint or palmar guard noted. He stated that therapy had been applying the splint to his right hand in the past but about 2 months ago nobody had been applying the splint. Resident #75 further stated that he really would like to have something on his right hand so it would not get worse. On 1/30/18 at 9:05 AM and 12:30 PM, Resident #75 was observed up in wheelchair. His right hand was in fist position and there was no splint or palmar guard noted. On 1/30/18 at 1:20 PM, the Occupational Therapist (OT) was interviewed. He stated that Resident #75 was on restorative nursing program for the application of the right upper extremity palmar guard. He added that in September 2017, Resident #75 was evaluated and treated by OT for positioning in wheelchair and he was discharged from therapy in December 2017. The OT further stated that he forgot to refer the resident back to restorative nursing for the application of the palmar guard to the right hand after discharge from therapy. On 1/30/18 at 2:13 PM, Restorative Aide #1 was interviewed. She stated that facility had 4 Restorative Aides and she had asked all the aides and revealed that Resident #75 was not on	F 688	one re-education to Occupational Therapist on expectations for services necessary to maintain range of motion and/or prevent further decrease range of motion and communication of recommendations using a Restorative Referral Sheet. Resident #75 was provided a right hand palm guard on 2/1/18. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)On February 1, 2018 Rehab Program Manager educated by Administrator and DON on expectations for services necessary to maintain range of motion and/or prevent further decrease in range of motion and communication of recommendations using a Restorative Referral Sheet. b)On February 1, 2018 Rehab Program Manager provided one on one education to Occupational Therapist on expectations for services necessary to maintain range of motion and/or prevent further decrease in range of motion and communication of recommendations using a Restorative Referral Sheet. c) Rehab Program Manager re-educated therapy staff on expectations for services necessary to maintain range of motion and/or prevent a further decrease in range of motion and communication of recommendations using a Restorative Referral Sheet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 36 their work load for splinting or range of motion exercises. On 2/1/18 at 10:50 AM, NA #5 (assigned to Resident #75) was interviewed. She stated that Resident #75 was not on their work load for splinting or range of motion exercises on his right hand. On 2/1/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the therapist to write a recommendation to the restorative nursing after the resident was discharged from therapy when there was a limitation in range of motion.	F 688	d)Rehab Program Manager will review the documentation of residents who have received therapy in the last 30 days to validate needs for continuation of care were communicated to nursing, to be completed by March 2, 2018. If there are other residents identified who require follow up, the information will be placed on the Communication Log and a Restorative Referral Sheet will be completed and given to the ADON for follow up. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Rehab Program Manager and/or Staff Development Coordinator will maintain a Communication Log to indicate when a resident is discharged from therapy what follow up is needed by nursing staff. Rehab Program Manager will provide ADON with a Restorative Referral Sheet for any residents who will require additional services. ADON will perform comparison audit of the Communication Log to the Restorative Referral Sheet weekly X 12 weeks to validate residents in need of nursing follow up have been communicated. Restorative Referral Sheets will be maintained by ADON and/or Staff Development Coordinator. b)The ADON and/or Staff Development Coordinator will report findings of audits monthly to the QAPI Committee monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 37	F 688	X 3 for tracking and trending purposes with all follow up action determined by the Interdisciplinary Team. 4.Title of person responsible for implementing the acceptable POC. a)Assistant Director of Nursing and Rehab Program Manager will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview, the facility failed to safely transfer a resident when one staff utilized a mechanical lift to transfer a resident who required the extensive assistance of 2 staff members for transfers. The unsafe transfer resulted in the resident (Resident #58) sustaining a hematoma and laceration to the head and a fracture to her right arm for 1 of 4	F 689	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law.	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 38 residents reviewed for accidents. The findings included: Resident #58 was admitted to the facility on 1/3/13 with diagnoses that included hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke) affecting the right dominant side, lack of coordination, muscle weakness, and dementia. The quarterly MDS dated 11/14/17 indicated Resident #58 ' s cognition was moderately impaired. She was assessed with no behaviors and no rejection of care. Resident #58 required the extensive assistance of 2 or more staff for transfers. She required the extensive assistance of 1 staff for bed mobility, dressing, and personal hygiene. Resident #58 was dependent on 1 staff with toileting and bathing. She was not steady on her feet and was only able to stabilize with staff assistance, she had impairment on one side of the upper and lower extremities, and she utilized a wheelchair. Resident #58 was indicated to always be incontinent of bowel and bladder. She had no falls noted. The plan of care for Resident #58 included the focus area of an ADL self-care performance deficit related dementia, hemiplegia, and stroke. This focus area was initiated on 7/5/17 and last revised on 11/17/17. The interventions included the extensive assistance of two staff to move between surfaces. The plan of care for Resident #58 also included the focus area of high risk for falls related to gait/balance problems, hemiplegia, incontinence, psychotropic medication, and being unaware of	F 689	F689 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Resident #58 was assessed and immediately transferred to the ER for ongoing treatment post fall. The staff involved in the event were interviewed regarding the event, as part of a full investigation launched by the ADON on 1/27/18 at 11:00 a.m. NA#1 was immediately suspended. The lift pad and the mechanical lift used during the event were immediately checked. No deficiencies noted to equipment. All mechanical lifts were taken out of service at that time. All transfers utilizing the mechanical lifts were suspended pending in-service from the ADON. The DON / ADON / Unit Coordinators completed an audit of current residents to verify transfer status. A new Transfer Assessment was completed on each resident to complete this verification. The RCS (Resident Care Specialist) assignment sheets for each resident was reviewed and updated to include the lift pad size. The DON / ADON/ Unit Coordinators re-educated all licensed and unlicensed Nursing Staff, to include all PRN, weekend, and agency, on safe operation and transfer utilizing a mechanical lift. This education included identification of lift status utilizing the RCS Assignment Sheet, return demonstration on how to properly attach sling, use the lift, and remove sling, obtaining the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 39	F 689		

safety needs. This focus area was initiated on 7/6/17 and last revised 11/17/17. The goal was for Resident #58 not to sustain a serious injury.

A hard copy Incident/Accident Report, completed by Nurse #1, indicated Resident #58 had an unwitnessed fall in her room on 1/27/18 at 10:05 AM. Resident #58 sustained a head injury. The description of the incident indicated Resident #58 was observed laying on the floor in her room beside the bed on her back. Resident #58 was noted vomiting when Nurse #1 entered the room. Bleeding was observed to the right side of Resident #58 ' s head. Equipment was noted to be involved in the incident/accident. The outcome to Resident #58 was noted as pain, bleeding, and head trauma. The Nurse Practitioner was notified at 10:10 AM and the Responsible Party (RP) was notified at 10:20 AM. Resident #58 was transferred to the Emergency Room (ER) by Emergency Medical Services (EMS) at 10:45 AM.

An electronic SBAR (Situation, Background, Assessment, Recommendation) form was completed on 1/27/18 for Resident #58 related to a change in condition. The form indicated Resident #58 was observed on the floor in her room on her back, bleeding and vomiting. Resident #58 was noted as appearing to be in distress with complaints of pain and bleeding from the right side of her head with a hematoma observed.

A physician ' s order dated 1/27/18 directed Resident #58 to be sent to the ER for evaluation and treatment related to a fall.

A hard copy Incident/Accident Investigation

appropriate lift pad under the resident, attaching the lift pad to the mechanical lift, all aspects of the transfers and safe movement during transfer, how to handle an event during transfer, repositioning and lift pad removal following the transfer, reporting resident□s tolerance of the procedure and any change in condition associated with the transfer. All Nursing Staff was re-educated on proper lift and transfers with two person assist. The process that led to the deficiency is NA #1 completed the resident transfer with one person assist.

2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited.

a)The ADON / SDC and Unit Coordinators will re-educate all Certified Nursing Staff on safe operation and transfer utilizing a mechanical lift. Education also provided on use of RCS assignments sheets to identify all aspects of specific residents transfer. Certified Nursing Staff re-education on providing safe transfers will be completed by March 2, 2018.

3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements.

a)The Unit Coordinators (ADON or SDC) will complete observation audits on 5 resident transfers on their respective units per week X 12 weeks to include all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 40	F 689		

Follow Up Report dated 1/27/18 and completed by Nurse Unit Manager (UM) #1 and signed by the Administrator and Director of Nursing (DON) was reviewed. The description of the incident was a fall with injury that occurred on 1/27/18 for Resident #58. The summary of the investigation/reasonable conclusion indicated Resident #58 was sitting on the side of her bed when Nursing Assistant (NA) #1 walked around to pull her back. Resident #58 leaned forward and fell to the floor. Recommendations/new interventions included staff education. The care plan was noted as updated on 1/27/18.

The interventions for Resident #58 ' s plan of care related to ADLs was updated on 1/27/18 to indicate she required the total assistance of 2 staff with a mechanical lift for transfers between surfaces.

An electronic Interdisciplinary Post Fall Review form was completed on 1/27/18. The form indicated Resident #58 had an unwitnessed fall on 1/27/18 at 10:05 AM. Resident #58 was observed laying on her back on the floor in her room vomiting when staff arrived to check on her. Resident #58 was transferred to the ER for a hematoma to the head and a 3 centimeter (cm) "gash" noted with bleeding. The form indicated the environmental factor of "equipment" was present at the time of the fall.

The hospital ER records dated 1/27/18 related to Resident #58 ' s fall were reviewed. The records indicated Resident #58 presented to the ER by EMS with complaints of an unwitnessed fall with laceration on the right side of her head and right shoulder pain. Resident #58 was noted to "not remember the fall". Resident #58 was indicated

certified and licensed staff on all shifts and weekends.

b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team.

4.Title of person responsible for implementing the acceptable POC.

a)The DON will be responsible for the implementation of the acceptable plan of correction.

5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.

a)March 2, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 41	F 689		

to have had a hematoma to the head, a laceration to the head that was sutured with a staple, and she was assessed with a fracture to the right humerus (long bone in the arm that runs from the shoulder to the elbow).

An electronic Transfer Evaluation form was completed by Nurse UM #1 on 1/27/18 at 6:05 PM. The form indicated Resident #58 was dependent on staff for 100% of transfers. Resident #58 was assessed as non-ambulatory and unable to sit on bedside without full back and head support. She was also noted with an arm fracture.

A physician ' s order dated 1/29/18 for Resident #58 indicated the following:
- Follow up appointment was to be scheduled with orthopedic physician for right arm fracture.
- Staples were to be removed from right scalp in 10 days (2/7/18).

The interventions for Resident #58 ' s plan of care related to falls were updated on 1/30/18 to indicate she transferred with a mechanical lift and 2 staff assist.

During an interview with Resident #83 on 1/29/18 at 3:00 PM he reported he witnessed Resident #58 fall in the room across the hall on 1/27/18 in the morning. He indicated the NA, unable to recall her name, utilized a mechanical lift without another staff member and Resident #58 fell, "busted her head", and went to the hospital. (Record review indicated Resident #83 was most recently readmitted to the facility on 11/20/17 and his 11/28/17 quarterly MDS indicated his cognition was fully intact.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 42	F 689		

An interview was attempted with Resident #58 on 1/29/18 at 3:20 PM. Resident #58 was alert with confusion. She was able to recall she hit her head and hurt her arm, but was unable to provide any details about how she fell.

An interview was conducted with the Social Services Director (SSD) on 1/30/18 at 1:10 PM. She stated NA #1 and Nurse #1 were assigned to Resident #58 at the time of her fall on 1/27/18.

An interview was conducted with Nurse #2 on 1/30/18 at 2:00 PM. She stated Resident #58 was not a fall risk although she had a fall over the past weekend. She was unable to provide any details on the fall that Resident #58 had on 1/27/18. She reported Resident #58 required a mechanical lift and 2 staff assistance for transfers. She indicated the facility utilized two types of mechanical lifts and 2 staff were required for the use of both types of lifts. During this interview, Nurse #2 stated Resident #83 was alert, oriented, and reliable with his statements.

An interview was conducted with NA #2 on 1/30/18 at 2:10 PM. She reported Resident #58 was not a fall risk although she had a fall over the past weekend. She stated she was not working at the time of Resident #58 ' s fall on 1/27/18 and she was unable to provide any details on the fall. She indicated Resident #58 required a mechanical lift for transfers and 2 staff assistance. She reported the facility utilized two types of mechanical lifts and 2 staff were required for the use of both types of lifts. During this interview, NA #2 stated Resident #83 was alert, oriented, and reliable with his statements.

A phone interview was attempted with NA #1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 43	F 689		

1/30/18 at 2:24 PM. The phone number provided was not in service.

A phone interview was conducted with Nurse #1 on 1/30/18 at 2:25 PM. She stated she was an agency nurse and she confirmed she was assigned to Resident #58 at the time of her fall on 1/27/18. She indicated she was in the process of completing her medication administration when NA #1 came up to her and said she needed her to come now as Resident #58 had fallen off the bed. Nurse #1 reported she immediately stopped what she was doing and went to Resident #58 ' s room. She stated Resident #58 was laying on her back, bleeding from the head, vomiting, and complaining of pain. Nurse #1 indicated she asked NA #1 how Resident #58 had fallen off the bed and she stated Resident #58 tried to get up on her own without assistance and she fell. Nurse #1 reported that Resident #58 had no history of trying to get up without assistance.

This phone interview with Nurse #1 continued. She indicated after she had assessed Resident #58 she contacted the physician, the RP, EMS and completed the Incident/Accident Report form. She stated the Assistant Director of Nursing (ADON) was the one who had completed the investigation into the fall. Nurse #1 revealed she was later informed by another NA and a medication aide, unable to recall their names, that Resident #83 had observed NA #1 use the mechanical lift with Resident #58 without another staff present. Nurse #1 confirmed she had observed the mechanical lift in Resident #58 ' s room when she assessed the resident after the fall. Nurse #1 additionally confirmed NA #1 had left Resident #58 in the room to come and get her for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 44	F 689		

An alternative phone number was requested from the SSD for NA #1 on 1/30/18 at 2:50 PM as the previous number that was provided was not in service. She indicated she was going to ask Human Resources (HR) for an alternative number.

An interview was conducted with the ADON on 1/30/18 at 2:51 PM. She stated she was working in her office at the time of Resident #58 ' s fall on 1/27/18. She indicated an NA, unable to recall the name, came into her office and said Resident #58 had fallen. She reported she went to Resident #58 ' s room and she was laying on the floor, blood from her head area, and it appeared she had vomited on herself. She indicated NA #1 was assigned to Resident #58 at that time. She stated following the fall an NA, the ADON was unable to recall the name, reported to her the resident across the hall (Resident #83) had observed the mechanical lift in Resident #58 ' s room at the time of her fall. The ADON indicated she then interviewed Resident #83. She stated Resident #83 informed her the door to Resident #58 ' s room was open and the curtain was pulled at the time of her fall. He confirmed he saw the mechanical lift in Resident #58 ' s room at the time her fall, but he was unable to see exactly what happened as the curtain was partially blocking his view.

This interview with the ADON continued. She stated she and the Weekend Nurse Supervisor then interviewed NA #1 and asked her what had happened. NA #1 admitted to utilizing the mechanical lift without another staff member ' s assistance. She stated she was putting Resident #58 back to bed. She reported she had gotten

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 45 her out of the mechanical lift and seated on the side of her bed. She indicated she then walked around to other side of the bed to position Resident #58, but during that time Resident #58 fell forward and hit the floor. The ADON indicated NA #1 had not provided a reason as to why she used the mechanical lift without another staff member, but she confirmed she had. She stated she suspended NA #1 that day as she had violated the facility ' s policy of using 2 staff assistance with all mechanical lifts. She indicated NA #1 was currently suspended as the investigation was still pending. On 1/30/18 at 3:20 PM the SSD indicated HR had no alternative phone number for NA #1. This resulted in NA #1 being unable to be reached for interview. An interview was conducted with the DON on 2/1/18 at 12:25 PM. She verified the facility ' s policy was for two staff to utilize mechanical lifts. She indicated she expected staff to follow the policy. She additionally indicated she expected staff to consistently implement the plan of care interventions related to transfers.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to	F 693		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 46 eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to check tube placement and residual prior to administering medications via gastrostomy (G) tube on 2 of 2 sampled residents observed during medication pass (Residents #123 & #316). Findings included: The facility's policy on Enteral Nutrition dated February 2017 was reviewed. The policy read in part "the nurse checks nasogastric, gastrostomy and jejunostomy tube placement prior to intermittent feeding and periodically during continuous feeding and prior to flushes and or medication administration". 1. Resident #123 was admitted to the facility on 1/27/05 with multiple diagnoses including cerebral palsy. The quarterly Minimum Data Set (MDS) assessment dated 1/2/18 indicated that Resident #123 had severe cognitive impairment and he was receiving tube feeding. Resident #123's care plan dated 1/2/18 was	F 693	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F693 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Nurse #4 was provided one to one re-education by the DON on the policy for Enteral Nutrition to include checking nasogastric, gastrostomy and jejunostomy tube placement and to check residual prior to administering medications on February 1, 2018. It was alleged that the facility failed to check tube placement and residual prior to administering medications	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 47 reviewed. One of the care plan problems was resident has alteration in nutrition related to enteral nutrition. The goal was resident will have adequate nutrition and hydration with enteral feeding ordered. The approaches included to flush feeding tube per order and with medication administration and free water as ordered. Resident #123's doctor's orders were reviewed. On 10/30/17, there was an order to check tube placement and on 12/26/17, to check residual of G tube prior to administering medications. On 1/26/18, there was a doctor's order for kidney, ureter, bladder (KUB) stat for nausea and vomiting and abdominal pain. On 1/29/18 at 9:30 AM, Resident #123 was observed in bed. There was a towel over his chest area with vomitus in it. The tube feeding was on hold at this time. On 1/31/18 at 9:05 AM, Resident #123 was observed during the medication pass. Nurse #4 was not observed to check tube placement and residual prior to administering the medications via G tube. On 1/31/18 at 9:40 AM, Nurse #4 was interviewed. He stated that he normally didn't check tube placement and residual prior to administering medications via G tube if there was no problem with the G tube. On 2/1/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check tube placement and residual prior to administering medication via tube per facility's policy and doctor's order.	F 693	via gastrostomy (G) tube; there was no negative outcome to Resident #123 or Resident #316. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Licensed Nurses are to follow policy for Enteral Nutrition to include checking nasogastric, gastrostomy and jejunostomy tube placement and to check residual prior to administering medications. All Licensed Nurses to include PRN, weekend, and agency staff to be re-educated by Staff Development and/or ADON on following the policy for Enteral Nutrition to include checking nasogastric, gastrostomy and jejunostomy tube placement and to check residual prior to administering medications to be completed by March 2, 2018. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The DON and/or Unit Coordinators will complete observation audits on five administrations of medications, to encompass all licensed staff, via tube per week X 12 weeks, to include all shifts and weekends. b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Assurance Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 48 2. Resident #316 was admitted to the facility on 1/11/18 with multiple diagnoses including cerebro vascular accident (CVA). The admission MDS assessment dated 1/17/18 indicated that Resident #316 had memory and decision making problems and he was receiving tube feeding. Resident # 316's care plan dated 1/17/18 was reviewed. One of the care plan problems was resident has alteration in nutrition related to enteral nutrition. The goal was resident will have adequate nutrition and hydration with enteral feeding ordered. The approaches included to flush feeding tube per order and with medication administration and free water as ordered. Resident #316's doctor's orders were reviewed. On 1/16/18, there was an order to check tube placement and to check residual of G tube prior to administering medications. On 1/31/18 at 9:20 AM, Resident #316 was observed during the medication pass. Nurse #4 was not observed to check tube placement and residual prior to administering the medications via G tube. On 1/31/18 at 9:40 AM, Nurse #4 was interviewed. He stated that he normally didn't check tube placement and residual prior to administering medications via G tube if there was no problem with the G tube. On 2/1/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to check tube placement and residual prior to administering medication via tube per facility's policy and doctor's order.	F 693	Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility failed to attempt alternatives prior to utilizing bilateral full-length bed rails for 1 of 1 residents (Resident #98) reviewed for bed rails. The findings included: Resident #98 was admitted to the facility on 7/2/09 and most recently readmitted on 6/9/17 with diagnoses that included cerebral palsy and seizure disorder. The annual Minimum Data Set (MDS) assessment dated 12/14/17 indicated Resident	F 700	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F700 1.The plan of correcting the specific deficiency. The plan should address the	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 50 #98 was rarely/never understood and rarely/never understands. He was assessed with short-term and long-term memory problems and severely impaired decision making. Resident #98 was dependent on 2 or more staff with transfers and personal hygiene. He was dependent on 1 staff for locomotion on/off the unit, eating, toileting, and bathing. Resident #98 required the extensive assistance of 2 or more staff with bed mobility and the extensive assistance of 1 staff with dressing. He was not steady on his feet and was unable to stabilize with staff assistance. Resident #98 was assessed with impairment on both sides of his upper and lower extremities. He had no falls noted and no physical restraints. The Care Area Assessment (CAA) related to falls for the 12/14/17 annual MDS indicated Resident #98 was at risk for falls related to impaired mobility, cerebral palsy, cognitive impairment, incontinence, and contractures. The plan of care for Resident #98 included, in part, the focus area of seizure disorder related to cerebral palsy and the focus area of risk for falls related to incontinence, unaware of safety needs, cognitive impairment, cerebral palsy, and contractures. These focus areas were initiated on 12/15/17 and most recently reviewed on 1/23/18. The plan of care for Resident #98 also included the focus area of potential for impairment to skin integrity related to dry skin, impaired mobility, incontinence and contractures. The interventions included padding Resident #98 ' s bed rails. This focus area and the intervention were initiated on 12/15/17 and most recently reviewed on 1/23/18.	F 700	process that lead to the deficiency. a) Resident #98 was referred to therapy for bed mobility, positioning and safety for trials of alternatives related to the use of full bed rails on February 2, 2018. Resident is currently on therapy caseload with a recommendation of a bed wedge and an in bed positioning system. Resident #98 re-assessed on February 6, 2018 bedrails not appropriate at this time. Other alternatives utilized at this time are a high low bed with roll mat and a foam wedge to improve positioning and comfort. February 6, 2018 Resident #98 Representative/Responsible Party educated on the use of alternative methods other then use of full bedrails by the Unit Coordinator. DON/ADON/ and unit coordinators completed 100% audits on all residents to ensure no other bed rail restraints were in place February 7, 2018. There were no additional residents noted with bed rail restraints. It was alleged that the facility to attempt alternatives prior to utilizing bilateral full-length bed rails. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)District Director of Clinical Services and Director of Nursing educated ADON, SDC and Unit Coordinators on February 5, 2018 that alternatives are to be attempted prior to the use of restraints, even if the restraint is being utilized per family request.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 51 A Bed Rail Safety Review assessment was completed for Resident #98 on 1/27/18. Resident #98 was assessed as non-ambulatory, unable to communicate his needs, unable to get in/out of bed independently, unable to reposition himself in bed independently, and he exhibited problems with balance and/or trunk controls. Resident #98 was noted as having uncontrolled or involuntary movements described as moving his hands and hitting the side of the bed rails while in bed. This Bed Rail Safety Review indicated Resident #98 ' s Responsible Party (RP) expressed a desire to have bed rails for safety. It additionally indicated that no alternatives to bed rails were attempted due to the RP ' s preference to utilize the bed rails. The use of bilateral full-length bed rails was noted to be continued. This form was signed by Nurse Unit Manager (UM) #1 on 1/28/18. An observation was conducted of Resident #98 in bed on 1/28/18 at 4:16 PM. The bed had bilateral full-length bed rails with full-length pads. A review of the physician ' s orders for Resident #98 was conducted on 1/31/18. There was no physician ' s order related to Resident #98 ' s bilateral full-length bed rails. A review of the comprehensive plan of care for Resident #98 was conducted on 1/31/18. The care plan had not addressed the use of bilateral full-length side rails for Resident #98. An interview was conducted with Nursing Assistant (NA) #6 on 1/31/18 at 4:15 PM. She stated she had worked at the facility for 2 years and had worked with Resident #98 during that entire length of time. She indicated Resident #98 was alert, not oriented, and non-verbal. She	F 700	b)ADON, SDC or Unit Managers will educate Licensed Nurses that alternatives are to be attempted prior to the use of any restraint, even if the restraint is being utilized per family request. This will be completed by March 2, 2018. c)ADON/Unit Coordinators to complete bedrail safety assessment/review on all residents by March 2, 2018. All assessments will be located in the electronic medical record. Residents are to have alternatives attempted prior to the use of any restraint if noted. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)There are no other restraints being utilized in the center at this time. b)ADON and/or Unit Coordinators to check all new physicians orders for restraints 3 times a week times 12 weeks. c)Observation audits to be completed by ADON and/or Unit Coordinators on 10 residents weekly X 12 weeks to ensure no restraints or full length bed rails are in use without proper documentation. d)If a new physician□s order is received for a restraint, the DON will audit to validate alternatives are attempted prior to initiation of restraint.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 52 stated Resident #98 moved around a lot in bed if he was agitated or needed something such as incontinent care. She reported it was this body language that helped to let the staff know if he needed something. NA #6 stated Resident #98 was minimally able to follow direction when he was being repositioned or provided with care. She reported he was dependent on staff for Activities of Daily Living (ADLs). She indicated Resident #98 had uncontrolled body movements at times. She stated he was a fall risk and had bilateral full-length bed rails with full-length pads. She reported the bilateral full-length bed rails had been in use for Resident #98 since she began working with him 2 years ago. She indicated sometimes Resident #98 removed the pads from the bed rails and the staff had to put them back in place. NA #6 indicated she believed the bilateral full-length bed rails were in place to prevent Resident #98 from rolling off the bed. An interview was conducted with Nurse UM #1 on 1/31/18 at 4:30 PM. She indicated Resident #98 was alert, not oriented, and primarily non-verbal. She stated Resident #98 had bilateral full-length bed rails. She indicated she believed they were initially implemented to prevent Resident #98 from rolling out of bed as a result of a seizure. Nurse UM #1 reported Resident #98 was the only resident in the facility with full-length bed rails. She confirmed she had completed the Bed Rail Safety Review dated 1/27/18 for Resident #98. Nurse UM #1 also confirmed no alternatives were attempted prior to implementing the bilateral full-length bed rails for Resident #98. She explained that alternatives were not attempted as bilateral full-length bed rails were the preference of Resident #98 ' s RP.	F 700	e)The DON will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a) The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 53 This interview with Nurse UM #1 continued. She indicated Resident #98 had agitation at times that was exhibited by yelling out nonsensical words and/or uncontrolled movements. She stated when Resident #98 was agitated while in bed he was able to position himself against the bed rails. She reported Resident #98 was a fall risk. She explained that sometimes when she entered his room in the morning half of his body was positioned up against the bed rail. She explained that if the bed rail was not in place Resident #98 would have fallen out of bed. Nurse UM #1 indicated the pads were added to the bilateral full-length bed rails so Resident #98 ' s skin integrity was not impaired by the bed rails when he positioned himself against them or as a result of hitting the rails during a seizure. An observation was conducted of Resident #98 in bed on 2/1/18 at 8:10 AM. The bed had bilateral full-length bed rails with full-length pads. An interview was conducted with the Director of Nursing (DON) on 2/1/18 at 12:25 PM. She stated Resident #98 ' s bilateral full-length bed rails were in place related to his seizures. She explained that the bed rails prevented Resident #98 from falling out of bed as result of a seizure. The DON stated Resident #98 ' s family was insistent on having the full-length bed rails for his safety.	F 700		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 54 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Medical Director interview, resident ' s physician interview, and Pharmacy Consultant interview, the Pharmacy Consultant failed to identify and	F 756	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 55 address the long-term use of a prophylactic (preventative) antibiotic for 1 of 1 residents reviewed for antibiotic usage (Resident #58). The findings included: Resident #58 was admitted to the facility on 1/3/13 with diagnoses that included dementia, bipolar disorder, anxiety disorder, and a history of urinary tract infections (UTIs). The significant change Minimum Data Set (MDS) assessment dated 7/1/17 indicated Resident #58 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. Resident #58 received antibiotic medication on 3 of 7 days during the MDS review period. A Nurse Practitioner (NP) note dated 9/1/17 indicated Resident #58 ' s diagnoses included a personal history of UTIs. The note stated Resident #58 ' s history of UTIs was stable and she remained on Bactrim (antibiotic medication) Monday, Wednesday, and Fridays for prophylaxis. Resident #58 was indicated to continue on Bactrim and utilize antibiotic stewardship. The quarterly MDS assessment dated 11/14/17 indicated Resident #58 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. Resident #58 received antibiotic medication on 3 of 7 days during the MDS review period. The plan of care included the focus area of Resident #58 receiving prophylactic antibiotic therapy related to the potential for UTI. This focus area was initiated on 7/5/17 and last reviewed on	F 756	in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F756 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Education will be provided by Medical Director to Pharmacy Consultant on the requirements for long-term use of prophylactic (preventative) antibiotic for 1 of 1 resident to be completed by March 2, 2018. It was alleged that the Pharmacy Consultant failed to identify and address the long-term use of a prophylactic (preventative) antibiotic for 1 of 1 resident reviewed for antibiotic usage (Resident #58). b)Resident #58 Nurse Practitioner was contacted by Unit Coordinator on February 15, 2018, regarding the use of prophylactic antibiotic therapy. The prophylactic antibiotic was discontinued. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)The Pharmacist is to identify and address long-term use of a prophylactic antibiotic. Education provided by the Medical Director to Pharmacy Consultant on the requirements for long-term use for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 56 11/17/17. A nursing note dated 1/26/18 indicated Resident #58 continued on the antibiotic Bactrim prophylactically for UTI. A review of Resident #58 ' s current physician ' s orders was conducted on 1/31/18. The orders included Bactrim 400-80 milligrams (mg) give 0.5 tablet one time a day every Monday, Wednesday, and Friday for UTI. This order was written by Resident #58 ' s physician on 2/1/17 with a start date of 2/3/17 and no stop date. The antibiotic was indicated to be administered to Resident #58 indefinitely. The monthly drug regimen reviews for Resident #58 as well as Pharmacy Consultant recommendations were reviewed from 2/2017 through 1/31/2018. There was no evidence in Resident #58 ' s medical record of the Pharmacy Consultant identifying and addressing the long-term use of a prophylactic antibiotic prescribed with no stop date. An interview was conducted with the Medical Director on 1/31/18 at 12:45 PM. He indicated he was involved in the Antibiotic Stewardship Program (ASP) at the facility and as per the ASP ' s policy he endorsed the avoidance of prophylactic antibiotics used on a long-term basis for the prevention of infections such as UTIs. The 9/1/17 NP note that indicated Resident #58 was to continue on a prophylactic antibiotic while utilizing antibiotic stewardship was reviewed with the Medical Director. He stated that prophylactic antibiotic usage seemed to be a contradicting statement to antibiotic stewardship. Resident #58 ' s current physician ' s order for Bactrim that had	F 756	prophylactic (preventative) antibiotics. b)The DON will perform an audit of physicians orders to establish which residents have physician s orders for prophylactic antibiotic. Any residents identified will have their physicians contacted for review for ongoing need for prophylactic antibiotic therapy. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The DON and / or Unit Managers will maintain a log of residents on prophylactic antibiotics. The log will include pharmacist recommendations related to the use of prophylactic antibiotic and the physician s response. b)The DON and or Unit Managers will report on the Log / Use of Prophylactic Antibiotic Therapy monthly to the Medical Director and the Interdisciplinary Care Team in the Quality Assurance Performance Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 57 been in place since 2/2017 was reviewed with the Medical Director. The Medical Director reported he had not prescribed this prophylactic antibiotic for Resident #58. He indicated this was an outlier as prophylactic antibiotics were not routinely prescribed. He indicated this needed to be addressed with her physician to see why it was prescribed for Resident #58 and to see if a trial run to eliminate the medication was appropriate. He stated he was going to speak with Resident #58 ' s physician. A phone interview was conducted with Pharmacy Consultant #1 on 2/1/18 at 11:20 AM. He indicated he was currently the interim Pharmacy Consultant as the previous Pharmacy Consultant retired several months ago. He stated he was unable to recall Resident #58. The 9/1/17 NP note that indicated Resident #58 was to continue on a prophylactic antibiotic while utilizing antibiotic stewardship was reviewed with Pharmacy Consultant #1. Resident #58 ' s current physician ' s order for Bactrim that had been in place since 2/2017 with no stop date was reviewed with Pharmacy Consultant #1. Pharmacy Consultant #1 stated he imagined he would have noticed Resident #58 was prescribed a long-term prophylactic antibiotic, but he may not have commented on it. He indicated sometimes he was dependent on prescriber ' s viewpoint in situations such as this with the use of a long-term prophylactic antibiotic. A phone interview was conducted with Resident #58 ' s physician on 2/1/18 at 2:52 PM. The physician verified he had prescribed Bactrim as a prophylactic antibiotic for Resident #58 in 2/2017. He additionally verified the Bactrim was ordered with no stop date. He indicated he believed it	F 756	5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 58 was initially recommended by a urologist, but he was not certain of that information. He stated he had spoken with the Medical Director regarding the long-term use of prophylactic antibiotics. The physician indicated he was planning to do a trial run to eliminate the prophylactic antibiotic for Resident #58 when he returned to the facility. An interview was conducted with the Director of Nursing (DON) on 2/1/18 at 12:25 PM. She stated she expected the Pharmacy Consultant to identify and address the long-term use of a prophylactic antibiotic prescribed with no stop date during the monthly Drug Regimen Reviews. She additionally indicated she expected the prescribing physician to follow the facility ' s Antibiotic Stewardship Program ' s protocol by avoiding the use prophylactic antibiotics used on a long-term basis for the prevention of infections such as UTIs.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 59 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Nurse Practitioner (NP) interview, the facility failed to follow doctor's order to discontinue a medication for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #92). Findings included: Resident #92 was admitted to the facility on 8/17/17 with multiple diagnoses including gastroesophageal reflux disease (GERD). The quarterly Minimum Data Set (MDS) assessment dated 12/7/17 indicated that Resident #92's cognition was intact. Resident #92 had doctor's orders dated 11/28/17 for Omeprazole 20 milligrams (mgs) by mouth daily and Famotidine 20 mgs by mouth at bedtime for GERD. On 12/14/17, the Pharmacy Consultant had recommended to discontinue Famotidine as resident was already on Omeprazole. On 12/20/17, the Nurse Practitioner responded to the recommendation stating "accept the recommendation and to implement as written" on 12/20/17. Review of the Medication Administration Records (MARs) for December 2017 and January 2018 revealed that Famotidine was not discontinued as	F 757	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F757 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)It is alleged the facility failed to follow doctors order to discontinue a medication reviewed for unnecessary medications (Resident #92) due to Assistant Director of Nursing not discontinuing a pharmacy recommendation on the Medication Administration Record (MAR) per physicians order. On February 1, 2018 Assistant Director of Nursing provided one on one education by DON on ensuring pharmacy recommendations are completed accurately and transcribed to MAR. On February 1, 2018 DON educated all Unit Coordinators on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 60 ordered. On 1/31/18 at 3:01 PM, the NP was interviewed. She stated that she expected the nurses to follow her order to discontinue the Famotidine as written. On 1/31/18 at 3:54 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON stated that she was responsible for the implementation of the pharmacy recommendations. She stated that she was aware of the order to discontinue the Famotidine but she forgot to discontinue it on the MAR. On 2/1/18 at 12:25 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the ADON to carry out the order to discontinue the Famotidine on the MAR.	F 757	ensuring pharmacy recommendations are completed accurately and transcribed to MAR. Famotidine was discontinued on 1/31/18 for resident #92. There was no outcome to resident #92. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)On February 1, 2018 Assistant Director of Nursing provided one on one education by DON on ensuring all pharmacy recommendations are completed accurately and transcribed to MAR. All pharmacy recommendations will be reviewed and checked with MD orders by March 2, 2018. b)On February 1, 2018 DON educated all Unit Coordinators on ensuring all pharmacy recommendations are completed accurately and transcribed to MAR. c)The DON will maintain a master copy and distribute the pharmacy recommendations to appropriate Unit Coordinator. Unit Coordinators will follow-up on recommendations and at completion will return the pharmacy recommendations to the DON, who will then validate that all orders have been transcribed to the MAR. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 61	F 757	regulatory requirements. a)DON will maintain a master copy of all pharmacy consults signed by DON indicating that a second check has been made and all orders have been transcribed as ordered. DON to perform comparison audit of the pharmacy consults x 12 weeks to validate. b)The DON will report findings of audits monthly to the QAPI Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the Interdisciplinary Team. 4.Title of person responsible for implementing the acceptable POC. a)DON and Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 62 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 63 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews, the facility failed to ensure there was a 14-day limit/stop date in place for as needed psychotropic medication for 3 of 6 residents reviewed for unnecessary medication (Residents #3, #80, and #86). 1. Resident #3 ' s annual Minimum Data Set dated 1/5/18 revealed the resident was severely cognitively impaired and had no behaviors. The resident ' s cumulative diagnoses included anxiety and depression. Resident #3 ' s care plan dated 1/22/18 revealed he had goals and interventions for anxiety, depression, and side effects of psychotropic medication. A review of the December 2017 and January 2018 medication administration record revealed the resident was documented as being evaluated for behaviors and psychotropic medication side effects on each shift every day. The resident had no behaviors. A physician order dated 6/7/17 revealed Ativan 0.5 mg as needed every 8 hours for anxiety with no stop date or on-going justification for use (a current order). A pharmacy review was documented each month for the past six months. There was no documentation of a gradual dose reduction for Ativan.	F 758	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F758 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)All January Pharmacy Recommendations were audited by DON, ADON, and Unit Coordinators. These audits were completed by February 21, 2018 with no other issues identified. b)Medical Director to provide provider education of the requirement for the 14-day limit/stop date in place for psychotropic medication usage to be completed by March 2, 2018. It was alleged that the facility failed to ensure there was a 14-day limit/stop date in place for as needed psychotropic medication for 3 residents (Resident #3, #80, and #86). c)Resident #3 (discontinued February 15, 2018) and #80 (discontinued on January 31, 2018) as needed Ativan was discontinued per physician order. Resident #86 as needed Haldol was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 64 On 1/31/18 at 3:00 pm an interview was conducted with Nurse #3. Nurse #3 stated he was not aware of the new regulation for a required 14-day timeframe/stop date for as needed psychotropic medication. Nurse #3 stated if he observed any order while he passed medication he would bring it to the attention of the Director of Nursing. On 1/31/18 at 12:00 pm an interview was conducted with the Nurse Practitioner (NP). The NP stated she was not aware that psychotropic medication ordered as needed required a stop date within 14 days or be re-ordered with a written justification. The NP stated she would review Resident #3 and #80 ' s orders. On 2/1/18 at 1:30 pm an interview was conducted with the Medical Director (MD). The MD stated that he was not aware of the new regulation that all as needed psychotropic medication ordered required a 14-day timeframe/stop date. The MD stated he would have the Administrator compile a report of all residents who received as needed psychotropic medication and address the issue. The MD also stated that he would follow the new regulation going forward when psychotropic medication was ordered. On 2/1/18 at 5:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she was not aware of the new regulation for a required 14-day timeframe/stop date for as needed psychotropic medication and would see that any resident that had an ongoing order would be corrected. 2. Resident #80 's annual Minimum Data Set dated	F 758	discontinued on February 13, 2018 per physician□s order. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Medical Director to provide provider education of the requirement for the 14-day limit/stop date in place for as needed psychotropic medications by March 2, 2018. b)Medical Director to provide the Pharmacist education on the requirement for the 14-day limit/stop date in place for as needed psychotropic medications by March 2, 2018. c)DON to provide the ADON, SDC and Unit Coordinators education on the requirement for the 14-day limit/stop date in place for as needed psychotropic medications by March 2, 2018. d)ADON, SDC and Unit Coordinators to provide the Licensed Nurses education on the requirement for the 14-day limit/stop date in place for as needed psychotropic medications by March 2, 2018. e)Unit Coordinators to conduct a medical record audit to determine if any additional residents are currently prescribed as needed psychotropic medication without a 14 day stop to be completed by March 2, 2018. Any residents noted with current orders for as needed psychotropic medication without a 14 day stop will have	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 65 11/6/18 revealed the resident had adequate hearing was understood and understands, was severely cognitively, and had no behaviors. The diagnoses were Alzheimer's disease, depression, and anxiety. A pharmacy review was documented each month for the past six months. Resident #80 had a history of behaviors. There was no documentation of a gradual dose reduction for Ativan. The psychiatry follow-up note dated 11/20/17 revealed Resident #80 ' s anxiety was stable on as needed Ativan Resident #80 ' s care plan dated 11/27/17 revealed the resident had goals and interventions for depression, anxiety, and antipsychotic medications for behavior management. A review of Resident #80's December 2017 medication administration record revealed the resident was documented as having received Ativan for one dose. A review of Resident #80's January 2018 medication administration record revealed the resident was documented as not having received Ativan. On 1/31/18 at 11:20 am an interview was conducted with Nurse #3. Nurse #3 stated that Resident #80 had no behaviors that he was aware of and had not administered Ativan. On 1/31/18 at 12:00 pm an interview was conducted with the Nurse Practitioner (NP). The NP stated she was not aware that psychotropic	F 758	their physician contacted for follow up. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Unit Coordinators will maintain a log of residents who are on as needed psychotropic medication without a 14 day stop and will contact the physician for follow up. b)Unit Coordinators will bring the log to the daily Clinical Meeting for review and discussion with the IDT Team and address with the Medical Director as needed. c)The DON or Unit Coordinators will report findings of audits monthly to the QAPI Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the Interdisciplinary Team. 4.Title of person responsible for implementing the acceptable POC. a)The Director of Nursing and or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 66 medication ordered as needed required a stop date within 14 days or be re-ordered with a written justification. The NP stated she would review Resident #3 and #80 ' s orders. On 2/1/18 at 1:30 pm an interview was conducted with the Medical Director (MD). The MD stated that he was not aware of the new regulation that all as needed psychotropic medication ordered required a 14-day timeframe/stop date. The MD stated he would have the Administrator compile a report of all residents who received as needed psychotropic medication and address the issue. The MD also stated that he would follow the new regulation going forward when psychotropic medication was ordered. On 2/1/18 at 3:00 pm an interview was conducted with the Director of Nursing (DON). The DON stated that she was not aware of the new regulation for a required 14-day timeframe/stop date for as needed psychotropic medication and would see that any resident that had an ongoing order would be corrected. 3. Resident #86 was admitted on 12/08/16 with cumulative diagnoses of altered mental status (AMS) and Wernicke Korsakoff Syndrome (thiamine deficiency causing chronic psychosis). A review of Resident #86's medical record indicated on admission 12/08/16 read he was prescribed Haldol (antipsychotic) 2 milligrams(mg) by mouth every six hours as needed for anxiety related to alcohol dependence. The last Haldol reorder was dated 10/25/17. A review of Resident #86'scumulative January 2018 physician orders indicated the Haldol was continued as previously ordered.	F 758	a)March 2, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 67	F 758		

A review of Resident #86's October 2017 Medication Administration Record (MAR) indicated he received one dose of his as needed Haldol on 10/27/17. There was no nursing note documenting the reason the Haldol was administered.

A physician progress note dated 11/19/17 read Resident #86 expressed no concerns or new issues, was doing well and no complaints. The medication Haldol (antipsychotic) was listed as a current medication to be administered as needed for anxiety. The physician progress note read as follows: "continue with current medications and supportive care." There was no evidence another order was written regarding the continued use of the as needed Haldol.

A consultant pharmacy recommendation dated 11/22/17 read the use of Haldol as needed could not be in place greater than fourteen days without a stop date. The recommendation was completed by Pharmacy Consultant #2 and was declined by the physician assistant for the Physician #1 on 12/07/17 stating "delusions occurring now".

A review of Resident #86's November 2017 MAR indicated he did not receive any doses of Haldol.

Resident #86's annual Minimum Data Set (MDS) dated 11/30/17 indicated moderate cognitive impairment and delusions. He was coded for having received seven of seven days of an antipsychotic. The Care Area Assessment (CAA) Summary for psychotropic medications dated 11/30/17 read his last gradual dose reduction for his scheduled antipsychotic Seroquel was attempted on 9/8/17 with physician documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 68	F 758		

evidence of contraindication on 10/6/17. The CAA did not address the continued use of Haldol.

A review of Resident #86's December 2017 MAR indicated he did not receive any doses of as needed Haldol.

Resident #86's care plan dated last revised on 12/04/17 read he was receiving antipsychotic medications for behavior management and alcohol induced amnestic disorder with cognitive deficits. Interventions included: Consult with pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly, discuss with the physician and family regarding the need for ongoing medications and to review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy.

A physician progress note dated 12/06/17 read Resident #86 was seen and examined. He expressed no concerns or new issues, was doing well and no complaints. The medication Haldol (antipsychotic) was listed as a current medication to be administered as needed for anxiety. The physician progress note read as follows: "continue with current medications and supportive care." There was no evidence another order was written regarding the continued use of the as needed Haldol.

A consultant pharmacy review dated 01/04/18 completed by Pharmacist Consultant #1 did not address the continued use of the as needed Haldol past the fourteen days stop day reordered 10/25/17.

A physician progress note dated 01/04/18 read

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 69	F 758		

Resident #86 was seen for a routine exam. There were no new concerns per staff. The note read to continue his Haldol as needed for anxiety. The physician progress note read as follows: "continue with current medications as ordered." There was no evidence another order was written regarding the continued use of the as needed Haldol.

A review of Resident #86's January 2018 MAR indicated he received one as needed dose of Haldol on 01/12/18. There was no nursing note documenting the reason the Haldol was administered.

In a telephone interview on 02/01/18 12:00 PM, the Pharmacy Consultant #2 confirmed he completed the pharmacy recommendation dated 11/22/17 to ensure Resident #86's Haldol was not to be prescribed more than fourteen days without a stop date. He further stated with antipsychotics such as Haldol an actual re-examination was required and not just a declination. He stated his pharmacy recommendations were sent to the Director of Nursing (DON).

In an interview on 02/01/18 at 12:23 PM the DON stated she was aware of the fourteen days stop date required for antipsychotics and it was her expectation that as needed antipsychotics only be prescribed for fourteen days with a stop date then reevaluated by the prescriber. The DON stated she received the pharmacy consult reports but did not offer any additional information as to how they were addressed for each individual resident. She stated it was an oversight.

In a telephone interview on 02/01/18 at 1:18 PM, Consultant Pharmacist #1 stated he did not notice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 70 the as needed Haldol recommendation was not addressed from Consultant Pharmacist #2 dated 11/22/17 when he reviewed Resident #86 in December 2017 and again in January 2018. He confirmed he made no pharmacy recommendations regarding Resident #86's as needed Haldol during his December 2017 and January 2018 reviews. In a telephone interview on 02/01/18 at 1:20 PM, Physician #1 stated it was not normal practice to use as needed antipsychotic but apparently Resident #86 was admitted with that order on 12/08/16 and it should have been stopped. Physician #1 stated it was an oversight. He confirmed awareness of the fourteen-day limited for antipsychotics with a stop date.	F 758		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain a medication error rate at 5% or less by not administering medications as ordered and not following the manufacturer's specification for enteric coated and extended release medications. There were five errors out of 25 opportunities observed. The medication error rate was 20% (Resident #316, #123 & #10). Findings included: 1.a. Resident #316 had a doctor ' s order dated	F 759	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F759	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 71 1/12/18 for Aspirin (used to treat pain/fever/inflammation) 325 milligrams (mgs) 1 tablet via Gastrostomy (G) tube daily and scheduled to be administered at 10:00 AM. The manufacturer's specification indicated that enteric coated tablets should not be crushed. On 1/31/18 at 9:20 AM, Resident #316 was observed during the medication pass. Nurse #4 was observed to prepare enteric coated Aspirin 325 mgs 1 tablet, crushed it and dissolved in water. Nurse #4 was observed to administer the dissolved medication via G-tube. On 1/31/18 at 9:40 AM, Nurse #4 was interviewed. He stated that there was no plain Aspirin in the medication cart so he had to use the enteric coated Aspirin. Nurse #4 acknowledged that he was not supposed to crush enteric coated aspirin, but he admitted he did. On 2/1/18 at 12:34 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the Nurse to administer medication as ordered and not to crush enteric coated medication. b. Resident #316 had a doctor's orders dated 1/12/18 for Senna/Docusate Sodium (laxative/stool softener) 8.6-50 mgs 1 tablet via Gastrostomy (G) tube twice daily and scheduled to be administered at 10:00 AM. On 1/31/18 at 9:20 AM, Resident #316 was observed during the medication pass. Nurse #4 was observed to prepare Senna 8.6 mgs 1 tablet, crushed it and dissolved in water. Nurse #4 was	F 759	1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Licensed Nurse #2 and Licensed Nurse #4 had a one to one in-service related to administering medications as ordered and following the manufacturer□s specifications for medication administration. It was alleged that the facility failed to maintain a medication error rate at 5% or less by not administering medications as ordered and not following the manufacturer□s specification for enteric coated and extended release for (Resident #316, #123, and #10) due to not administering medications as ordered and or not following the manufacturer□s specifications for medication administration. There was no outcome to Resident #316, #123 or #10. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Licensed Nurses to include PRN, weekend, and agency will be re-educated prior to working on the floor on administering medications as ordered and following the manufacturer□s specifications for medication administration by the DON, ADON, SDC or Unit Coordinators. This will be completed by March 2, 2018. b)Licensed Nurses will have Medication Administration Competencies Training by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 72 observed to administer the dissolved medication via G-tube. On 1/31/18 at 9:40 AM, Nurse #4 was interviewed. He stated that he didn't realize the order was Senna and Docusate Sodium and he administered plain Senna. On 2/1/18 at 12:34 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the Nurse to administer medication as ordered. 2. Resident #123 had doctor's orders for Robinul (anticholinergic drug) 1 milligrams (mgs.) 1 tablet twice a day, Baclofen (used to treat spasm/pain) 20 mgs 1 tablet three times a day, Metoprolol (used to treat hypertension) 25 mgs 1 tablet three times a day, Phenobarbital (used to treat seizures) 64.8 mgs 1 tablet twice a day and Phenergan (used to treat nauseas and vomiting) 25 mgs 1 tablet every 6 hours. The medications were scheduled to be administered at 10:00 AM. On 1/31/18 at 9:05 AM, Resident #123 was observed during the medication pass. Nurse #4 was observed to prepare the medications including the Robinul, Baclofen, Metoprolol and Phenergan, crushed them and dissolved them in water. Nurse #4 was not observed to prepare the Phenobarbital. Prior to the medication administration, Nurse #4 was interviewed. He admitted that he forgot to pull 1 tablet of Phenobarbital from the narcotic box. He was observed to pull 1 tablet of Phenobarbital, crushed it and dissolved it in water. Nurse #4 was observed to administer the dissolved medications via G tube.	F 759	the DON, ADON, SDC or Unit Coordinators. This will be completed by March 2, 2018. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Medication Administration observation audits will be performed on 5 Licensed Nurses on all units weekly X 12 weeks to include all shifts and weekends. The audits will be completed by DON and/or Unit coordinators. b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Performance Improvement Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 73	F 759		

On 2/1/18 at 12:34 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the Nurse to administer the medications as ordered.
3. Omnicare Pharmacy LTC (Long Term Care) facility Pharmacy Services and Procedures manual dated 2017 stated, in part, the following medications should not be opened and/or crushed: 1. Duloxetine (delayed release with enteric coated pellets). Manufacturer had data on the demonstrating stability with sprinkling contents into applesauce or into apple juice and immediately administrating the product orally. Do not crush. 2. Diltiazem HCL--extended release. Do not crush.

a. On 1/31/18 at 7:45 AM, Nurse #2 was observed administering medications to Resident #10. Nurse #2 opened Diltiazem HC 240 mg ER (extended release), poured the medication in with Resident #10 ' s other medications and crushed the medication. Nurse #2 placed the crushed medication in applesauce and administered the medication to Resident #10.

A review of the Medication Administration card for Diltiazem HC stated "May open capsule. Do not chew or crush".

On 1/31/18 at 9:00AM, an interview was conducted with Nurse #2. She stated she would normally crush all the other medications and sprinkle the Diltiazem over the crushed medications. She said she was nervous and should not have crushed the Diltiazem with the other medications.

On 1/31/18 at 3:00 PM, an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 74	F 759		

conducted with the Director of Nursing who stated she expected staff to follow pharmacy and manufacturer's recommendations regarding opening capsules and crushing medications.

On 02/01/18 at 11:34 AM, an interview was conducted with Pharmacy Consultant #1 who stated, regarding the Diltiazem, the capsule could be opened but should not be crushed.

b. On 1/31/18 at 7:45 AM, Nurse #2 was observed administering medications to Resident #10. Nurse #2 opened Duloxetine HC 60 milligrams capsule, poured the medication in with Resident #10 ' s other medications and crushed the medication. Nurse #2 placed the crushed medication in applesauce and administered the medication to Resident #10.

A review if the Medication Administration card for Duloxetine HC 60 milligrams stated "Do not chew or crush. Swallow capsule whole."

On 1/31/18 at 9:00AM, an interview was conducted with Nurse #2. She stated she would normally crush all the other medications and sprinkle the Duloxetine over the crushed medications. She said she was nervous and should not have crushed the Duloxetine with the other medications.

On 1/31/18 at 3:00 PM, an interview was conducted with the Director of Nursing who stated she expected staff to follow pharmacy and manufacturer's recommendations regarding opening capsules and crushing medications.

On 02/01/18 at 11:34 AM, an interview was conducted with Pharmacy Consultant #1 who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 75 stated there was new information on Duloxetine and if a resident was having trouble swallowing the capsule, it could be opened but not crushed.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date multi dose medications when opened and failed to discard expired medications in 1 (300 hall) of 2 medication rooms and 3 (100, 600 and 700 hall	F 761	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 76 medication carts) of 4 medication carts observed. Findings included: The facility's policy on Storage and Expiration Dating of Drugs and Biologicals dated 12/1/07 was reviewed. The policy read in part "once any drug or biological package is open, the facility should follow manufacturer/supplier guidelines when respect to expiration dates for opened medications". 1. On 2/1/18 at 9:32 AM, the 600 long hall medication cart was observed with Nurse # 6. The following was observed: a. used Flovent diskus (used to treat Asthma) 50 microgram (mcg) - undated The manufacturer's specification written on the box read "date diskus when removed from the foil pouch and discard 1 month after removal from the foil pouch". b. used Advair diskus (used to treat Asthma and Chronic Obstructive Pulmonary Disease (COPD)) 250/50 mgs - undated The manufacturer's specification written on the box read "date diskus when removed from the foil pouch and discard 6 weeks after removal from the foil pouch". c. used Symbicort (used to treat Asthma and COPD) 160/4.5 inhaler - undated The manufacturer's specification written on the box read "date diskus when removed from the foil pouch and discard 3 months after removal from	F 761	of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F761 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)It was alleged that the facility failed to date multi dose medications when opened and failed to discard expired medications. The medications identified were discarded per policy. b)Licensed Nurses #6, 7 and 4 were provided one to one education by the DON on the requirement of labeling/dating drugs and the process of discarding open/expired medications on February 2, 2018. c)On February 2, 2018 Unit Coordinators inspected each medication cart and the medication rooms on their respective units to validate multi dose medications were dated when opened and for expired medications. Any items not properly dated or expired were discarded per policy. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Licensed Nurses, to include PRN, weekend, and agency will be re-education by SDC (Staff Development Coordinator) and/or DON and/or ADON and / or the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 77 the foil pouch". On 2/1/18 at 9:40 AM, Nurse #6 was interviewed. She stated that the inhalers should have been dated when opened but they were not. Nurse #6 stated that the night shift nurses were responsible for checking the medications carts every night and the pharmacy staff occasionally checked for expired and undated medications. On 2/1/18 at 12:24 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the nurses to date the inhalers and the PPD when opened and to follow the manufacturer's specification for expiration dates. The DON further stated that the unit managers were responsible for checking the medications carts weekly for expired and undated medications. 2. On 2/1/18 at 10:35 AM, the 100 hall medication cart was observed with Nurse #7. There was an opened vial of Purified Protein Derivatives (PPD) that was undated. Nurse #7 stated that she just used the PPD vial to administer a PPD test to a new admit resident. The PPD vial has less than 1 milliliter (ml) left on the bottle. The manufacturer's specification for Purified Protein Derivatives (PPD) revealed that it was good for 30 days after opening. On 2/1/18 at 10:40 AM, Nurse #7 was interviewed. She stated that the PPD should have been dated when opened but it was not. Nurse #7 was observed to discard the opened vial of PPD. On 2/1/18 at 12:24 PM, the Director of Nursing	F 761	Unit Coordinators on the requirement of labeling/dating drugs and the process of discarding open/expired medications by March 2, 2018. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Unit Coordinators or Nurse Supervisor will complete audits on 1 medication carts and the medication room on their respective units weekly X 12 weeks. b)The DON and/or Unit Coordinators will report findings of audits monthly to the Quality Assurance Performance Improvement (QAPI) Committee monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)The DON and/or Unit Coordinators will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 78	F 761		

(DON) was interviewed. The DON stated that she expected the nurses to date the inhalers and the PPD when opened and to follow the manufacturer's specification for expiration dates. The DON further stated that the unit managers were responsible for checking the medications carts weekly for expired and undated medications.

3. Observations on 2/01/18 at 9:05 AM of the facility's 300/400 hall medication room revealed an opened NovoLog Flex Pen (Insulin) filled by the pharmacy on 10/29/17 and dated as opened on 12/14/17.

During an interview with the Assistant Director of Nursing (ADON) on 02/01/18 at 9:05 AM she stated the Novolog Flex Pen should have been discard 30 days after it was opened on 12/14/17.

During an interview on 02/01/18 at 12:23 PM, the Director of Nursing (DON) stated it was her expectation that medications be sent back the pharmacy when expired and medications be dated when opened. The DON further stated unit managers were responsible for weekly review the medication carts and medication rooms for items not dated and expired.

4. Observations on 02/01/18 at 10:20 AM of medications and inhalers stored on the medication cart labeled 700 hall-front revealed. There were three opened multi-dose bottles of Flonase that were not dated when opened. These bottles of Flonase were filled by the pharmacy on the following dates; 6/08/17, 09/06/17 and 10/31/17. Also observed was one IPRATOP inhaler used to treated Chronic Obstructive Pulmonary Disease (COPD) dated filled by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 79 pharmacy on 11/12/17 was undated when opened. During an interview with Nurse #4 on 02/01/18 at 10:20 AM he stated the bottles of Flonase and the IPRATOP inhaler should have been dated when opened. He stated it was the facility policy to date items when opened but they were overlooked. During an interview on 02/01/18 at 12:23 PM, the Director of Nursing (DON) stated it was her expectation that medications be sent back the pharmacy when expired and medications be dated when opened. The DON further stated unit managers were responsible for weekly review the medication carts and medication rooms for items not dated and expired.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 80 (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 81 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to maintain accurate medical records for 1 (Resident #86) of 6 residents reviewed for unnecessary medications and 1 (Resident #55) of 1 reviewed for behaviors. The findings included: 1. Resident #86 was admitted on 12/08/16 with a diagnosis of Wernicke Korsakoff Syndrome (thiamine deficiency causing chronic psychosis). A review of a pharmacy recommendation dated 08/02/17 read to discontinue the use of thiamine and folic acid. Physician #1 agreed with the recommendation on 08/08/17. Resident #86's thiamine and folic acid was discontinued as ordered on 08/17/17. A physician progress note dated 09/14/17 read Resident #86 continued to receive thiamine and folic acid daily. A nutrition status review dated 10/05/17 read Resident #86 continued to receive thiamine and folic acid daily. A physician progress note dated 10/12/17 read Resident #86 continued to receive thiamine and	F 842	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F842 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Medical Director to educate all providers on completing/charting accurate medical information. This is to be completed by March 2, 2018. It was alleged that the facility failed to maintain accurate medical records for (Resident #86 and #55). b)DON to educate the Registered Dietician (RD) on completing/charting accurate medical information. This is to be completed by March 2, 2018. It was alleged that the facility failed to maintain accurate medical records for (Resident #86 and #55).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 82 folic acid daily. A nutrition status review dated 10/25/17 read Resident #86 continued to receive thiamine and folic acid daily. A physician progress note dated 11/19/17 read Resident #86 continued to receive thiamine and folic acid daily. A nutrition annual status review dated 11/30/17 read Resident #86 continued to receive thiamine and folic acid daily. A physician progress note dated 12/06/17 read Resident #86 continued to receive thiamine and folic acid daily. In a telephone interview on 02/01/18 at 10:00 AM, the Registered Dietician (RD) stated she routinely reviewed the electronic and hard copy medical record but she must have overlooked that Resident #86's thiamine and folic acid was discontinued on 08/17/17. In a telephone interview on 02/01/18 at 1:20 PM, Physician #1 stated his monthly progress notes were inaccurate and did not reflect Resident #86's medication regime. In an interview on 02/01/18 at 1:40 PM, the Administrator stated it was her expectation that Resident #86's medical record be accurate. 2. Resident #55 was admitted to the facility 1/5/15. Cumulative diagnoses included dementia without behavioral disturbance, major depressive disorder, generalized anxiety disorder and delusional disorder.	F 842	c)Resident #86 current notes from provider and RD currently reflect the resident is no longer on Thiamine. d)Resident #55 Psychiatric notes are filed in the medical record. e)Audit to be completed by Medical Records Staff and Registered Dietician by March 2, 2018 to validate all records are accurate and up to date. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)Medical Director to educate all providers on completing/charting accurate medical information by March 2, 2018. b)DON to educate the Registered Dietician (RD) on completing/charting accurate medical information by March 2, 2018. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)Unit Coordinators will randomly audit three medical records per week for 12 weeks on their respective units to validate provider progress notes and RD notes accurately reflect residents□ status and are submitted to the center and filed timely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 83 A psychiatric progress note dated 5/26/17 stated Resident #55 had a previous mental history of moderate dementia with behavioral disturbance and depression. Resident #55 was seen for a routine follow up psychiatric evaluation for medical management of psychotropic medications and assessment of mood and behaviors. She occasionally attempted to get out of her wheelchair and had yelling outbursts. Current medications included Lexapro (antidepressant), Donepezil (dementia medication), Lorazepam (anti-anxiety), Namenda (for dementia), Haldol (anti-psychotic) Seroquel (anti-psychotic) and Depakote (mood disorder). Visit frequency was documented that Resident #55 was seen by psychiatry every four weeks. A psychiatric progress note dated 7/28/17 stated Resident #55 was seen for a routine psychiatric evaluation for medical management of psychotropic medications and assessment of mood and behaviors. Visit frequency was documented that Resident #55 was seen by psychiatry every four weeks. A Quarterly Minimum Data Set (MDS) dated 11/9/17 indicated Resident #55 had short term and long-term memory impairment and was severely impaired in cognition. No mood or behaviors were noted during the assessment period. It was documented that Resident #55 had delusions. A Nurse Practitioner note dated 1/31/18 stated Resident #55 had no reported behaviors. She was being followed by in house psychiatry. Medical record review revealed there were no further psychiatric progress notes/ consultations	F 842	4.Title of person responsible for implementing the acceptable POC. a)Unit Coordinators and or DON will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 84 after 7/28/17. On 2/1/18 at 1:05 PM, an interview was conducted with the Social Services Director. She stated psychiatric follow up notes were usually sent as an email to the Social Worker who printed out the psychiatric follow up note and placed in in Resident #55 ' s medical record. She stated the last note that had been sent by psychiatric services was on 7/28/17. On 2/1/18 at 1:13 PM, a telephone interview was conducted with the Psychiatric Nurse Practitioner. She stated she sees residents on case load when they have a problem and every 8 weeks as a minimum. She stated she put every four weeks on her consultations and she would make the decision to see the resident or not. The Psychiatric Nurse Practitioner stated she came to the facility every week and there were many residents on caseload. She also stated Medicare would not pay for monthly visits. The Psychiatric Nurse Practitioner indicated she saw Resident #55 in February, March, April and May 2017 because Resident #55 was having issues. She said she also saw Resident #55 on 9/22/17, 10/20/17, 12/1/17 and 1/5/18. She stated she emailed the follow up notes to the social worker and the social worker placed the notes on the medical record. She said did not recall if she wrote a follow-up note for those dates. On 2/1/18 at 1:35 PM, an interview was conducted with the Director of Nursing who stated she expected the medical records to be complete and the psychiatric notes should have been placed in the medical record.	F 842		
F 865	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt	F 865		3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865 SS=G	Continued From page 85 CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility ' s Quality Assurance and Performance Improvement committee (QAPI) failed to maintain implemented procedures and to monitor the interventions that the committee put into place in February 2017. This was for eight (8) recited deficiencies (self- determination, Minimum Data Set (MDS) accuracy, Activities of daily living (ADL) care for dependent residents, increase/ prevent decrease in range of motion/ mobility, drug regime free from unnecessary drugs, free from unnecessary psychotropic medications, free of medication error rate of 5% or more) which were originally cited on 2/9/17 during the recertification/ complaint investigation survey and on the current recertification/ complaint investigation survey on 2/1/18. There was also	F 865	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F865 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Facility Administrator conducted a Quality Assurance and Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 86 one recited deficiency (free of accident hazards) that was originally cited during the complaint investigation of 7/23/17 and on the current recertification/ complaint investigation of 2/1/18. The continued failure of the facility during the two federal surveys of record and complaint investigation show a pattern of the facility ' s inability to sustain an effective QAPI program. The findings included: This tag is cross referred to: 1. F561-self-determination: Based on record review, observations and resident, staff and family interviews, the facility failed to honor the resident ' s preference to communicate in Spanish resulting in the staff ' s inability to assess him and determine his needs. This was evidenced by 1 of 1 residents reviewed for communication/sensory (Resident #3). During the recertification survey 0f 2/9/17, the facility was cited F242 for failure to honor a resident ' s choice in bathing. 2. F 641-Accuracy of assessments: Based on record review, observation, and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of physical restraints (Residents #98 and #128) and behaviors (Residents #9 and #57) for 4 of 35 residents reviewed. During the recertification survey of 2/9/17, the facility was cited F278 for failure to code the MDS accurately in the areas of Preadmission Screening and Resident Review level 2, behaviors and discharge status.	F 865	(QAPI) Committee meeting on February 21, 2018 to discuss the current survey citations from survey exit. The QAPI Committee determined the alleged process breakdown occurred when the center achieved substantial compliance the audits were discontinued per the plan of correction and that further random auditing needed to have occurred throughout the year at the QAPI Committee□s discretion. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)The QAPI Committee determined random audits from the plan of correction should be conducted throughout the year to validate sustained compliance ongoing. 3.The monitoring procedure to ensure that the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The Administrator will educate the Quality Assurance Improvement Committee by February 21, 2018 regarding accurately reporting and revising current action plans as well as developing and implementing a new action plans to assure compliance with state and federal regulations in the facility. The QAPI Committee determined audits from the plan of correction will be conducted monthly throughout the year to validate sustained compliance ongoing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 87 3. F 677-ADL care provided for dependent residents: Based on record review, observation and staff interview, the facility failed to provide incontinent care and nail care upon request for 2 of 4 sampled residents reviewed for activities of daily living (ADL) (Residents # 9 & #111). During the recertification survey of 2/9/17, the facility was cited F312 for failure to provide personal care and hygiene including showers and nail care. 4. F 688-Increase/ prevent decrease in range of motion/ mobility: Based on record review, observation and staff and resident interview, the facility failed to provide treatment to prevent further decrease in range of motion for 1 of 4 sampled residents reviewed for range of motion (Resident #75). During the recertification survey of 2/9/17, the facility was cited F318 for failure to apply splints as ordered by the physician. 5. F 689-Free of Accident Hazards/Supervision/ Devices: Based on record review, resident interview, and staff interview, the facility failed to safely transfer a resident when one staff utilized a mechanical lift to transfer a resident who required the extensive assistance of 2 staff members for transfers. The unsafe transfer resulted in the resident (Resident #58) sustaining a hematoma and laceration to the head and a fracture to her right arm for 1 of 4 residents reviewed for accidents. During the complaint investigation of 7/23/17, the facility was cited F323 for failure to safely transfer one of one residents resulting in a fracture.	F 865	The QAPI Committee determined audits from the plan of correction will be reviewed in the QAPI Meeting monthly throughout the year to validate sustained compliance ongoing. Should any interdisciplinary team member find that the facility may need an Ad Hoc Quality Assurance and Performance Improvement meeting for a facility compliance issue, the Administrator will organize a meeting and notify all team members in order revise any present action plan or determine the need for a new action plan in order to maintain compliance in the facility. Quality assurance monitoring will take place at each Quality Assurance Performance Improvement meeting monthly and any Ad Hoc meetings held. This monitoring tool will be signed off by the responsible Interdisciplinary team member after each meeting accepting and acknowledging all monitoring and revisions set forth by the Quality Assurance and Performance Improvement Committee. The Vice President of Operations or designee will review the facility QAPI meeting minutes at least monthly x 3 months. 4.Title of person responsible for implementing the acceptable POC. a)The Administrator is ultimately responsible for implementing the plan of correction and to ensure the plan of correction is sustained ongoing. 5.Dates when corrective action will be completed. The corrective action dates	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 88 6. F 757-Drug regime free from unnecessary drugs: Based on record review and staff and Nurse Practitioner (NP) interview, the facility failed to follow doctor's order to discontinue a medication for 1 of 7 sampled residents reviewed for unnecessary medications (Resident #92). During the recertification survey of 2/9/17, the facility was cited F329 for failure to follow the Nurse Practitioner orders and monitor potassium medication. 7. F 758-Free from unnecessary psychotropic meds/ as needed use: Based on record review and staff and physician interviews, the facility failed to ensure there was a 14-day limit/stop date in place for as needed psychotropic medication for 3 of 6 residents reviewed for unnecessary medication (Residents #3, #80, and #86). During the recertification survey of 2/9/17, the facility was cited F329 for failure to follow the Nurse Practitioner orders and monitor potassium medication. 8. F 759-Free of medication error rates of 5% or more: Based on record review, observation and staff interview, the facility failed to maintain a medication error rate at 5% or less by not administering medications as ordered and not following the manufacturer's specification for enteric coated and extended release medications. There were five errors out of 25 opportunities observed. The medication error rate was 20% (Resident #316, #123 & #10). During the recertification survey of 2/9/17, the facility was cited F332 for failure to maintain	F 865	must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 89	F 865		

medication error rate at 5% or below as evidenced by 2 errors out of 28 opportunities resulting in 7.14$ med error rate.

9. F 761-Label/ store drugs/biologicals: Based on record review, observation and staff interview, the facility failed to date multi dose medications when opened and failed to discard expired medications in 1 (300 hall) of 2 medication rooms and 3 (100, 600 and 700 hall medication carts) of 4 medication carts observed.

During the recertification survey of 2/9/17, the facility was cited F431 for failure to date multi-dose vials of injectable medications after opening in 2 of 3 medication storage refrigerators.

On 2/1/18 at 1:54 PM, an interview was conducted with the Administrator. The Administrator stated that the facility has a QAPI committee that consisted of the Medical Director, Administrator, Director of Nursing, Pharmacy Consultant and all the department heads. The committee met monthly. She said there had been a lot of areas that the facility had been working on and corrected successfully since the Administrator and Director of Nursing came in May 2017. The following areas had been identified and continued to be reviewed-complaints about cold food, call light response had improved and continued to be monitored, falls, pressure ulcers, weight loss, MDS accuracy, care plans and abuse. Regarding the repeat citations, the Administrator said the facility has continued to build a cohesive team that could monitor and correct deficiencies. They have had increased meeting as needed for falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 865	Continued From page 90 and any areas that might need increased attention and the plan might need to be adjusted sooner than monthly. She said the QAPI committee had adjusted and changed plans and it continued to be an ongoing process to reach, attain and maintain compliance with all the issues identified.	F 865		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Medical Director interview, resident ' s physician interview, and pharmacy consultant interview, the facility failed to follow its Antibiotic Stewardship Program as evidenced by the failure to identify and address the long-term use of a prophylactic (preventative) antibiotic for 1 of 1 residents reviewed for antibiotic usage (Resident #58). The findings included: A review of the Antibiotic Stewardship Program ' s policy dated 2017 indicated antibiotics were only to be used for as long as needed to treat infections, minimize the risk of relapse, or control active risk to others. The physician ' s responsibility when considering prescribing	F 881	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or solely because it is required by the provision of the Federal & State Law. F881 1.The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency. a)Education provided by Medical Director to Pharmacy Consultant on the	3/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 91 antibiotics included, in part, to determine duration of therapy and to avoid the long-term use of antibiotic prophylaxis for preventing infections such as Urinary Tract Infections (UTIs). Resident #58 was admitted to the facility on 1/3/13 with diagnoses that included dementia, bipolar disorder, anxiety disorder, and a history of urinary tract infections (UTIs). The significant change Minimum Data Set (MDS) assessment dated 7/1/17 indicated Resident #58 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. Resident #58 received antibiotic medication on 3 of 7 days during the MDS review period. A Nurse Practitioner (NP) note dated 9/1/17 indicated Resident #58 ' s diagnoses included a personal history of UTIs. The note stated Resident #58 ' s history of UTIs was stable and she remained on Bactrim (antibiotic medication) Monday, Wednesday, and Fridays for prophylaxis. Resident #58 was indicated to continue on Bactrim and utilize antibiotic stewardship. The quarterly MDS assessment dated 11/14/17 indicated Resident #58 ' s cognition was moderately impaired. She had no behaviors and no rejection of care. Resident #58 received antibiotic medication on 3 of 7 days during the MDS review period. The plan of care included the focus area of Resident #58 receiving prophylactic antibiotic therapy related to the potential for UTI. This focus area was initiated on 7/5/17 and last reviewed on 11/17/17.	F 881	requirements for long-term use of prophylactic (preventative) antibiotic for 1 of 1 resident to be completed by March 2, 2018. It was alleged that the Pharmacy Consultant failed to identify and address the long-term use of a prophylactic (preventative) antibiotic for 1 of 1 resident reviewed for antibiotic usage (Resident #58). b)Resident #58 Nurse Practitioner was contacted by unit coordinator on February 15, 2018 regarding the use of prophylactic antibiotic therapy. The prophylactic antibiotic was discontinued. 2.The procedure for implementing the acceptable plan of correction for the specific deficiency cited. a)The Pharmacist is to identify and address long-term use of a prophylactic antibiotic. Education provided by the Medical Director to Pharmacy Consultant on the requirements for long-term use for prophylactic (preventative) antibiotics. b)The DON will perform an audit of physicians orders to establish which residents have physicians orders for prophylactic antibiotic. Any residents identified will have their physicians contacted by the DON and/or ADON and/or Unit Coordinators for review for ongoing need for prophylactic antibiotic therapy. This audit will be completed by March 2, 2018. 3.The monitoring procedure to ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 92 A nursing note dated 1/26/18 indicated Resident #58 continued on the antibiotic Bactrim prophylactically for UTI. A review of Resident #58 ' s current physician ' s orders was conducted on 1/31/18. The orders included Bactrim 400-80 milligrams (mg) give 0.5 tablet one time a day every Monday, Wednesday, and Friday for UTI. This order was written by Resident #58 ' s physician on 2/1/17 with a start date of 2/3/17 and no stop date. The antibiotic was indicated to be administered to Resident #58 indefinitely. There was no evidence in Resident #58 ' s medical record of the Pharmacy Consultant identifying and addressing the long-term use of a prophylactic antibiotic. An interview was conducted with the Medical Director on 1/31/18 at 12:45 PM. He indicated he was involved in the Antibiotic Stewardship Program at the facility. The 9/1/17 NP note that indicated Resident #58 was to continue on a prophylactic antibiotic while utilizing antibiotic stewardship was reviewed with the Medical Director. He stated that prophylactic antibiotic usage seemed to be a contradicting statement to antibiotic stewardship. Resident #58 ' s current physician ' s order for Bactrim that had been in place since 2/2017 was reviewed with the Medical Director. The Medical Director reported he had not prescribed this prophylactic antibiotic for Resident #58. He indicated this was an outlier as prophylactic antibiotics were not routinely prescribed. He indicated this needed to be addressed with her physician to see why it was prescribed for Resident #58 and to see if a trial	F 881	the plan of correction is effective and that specific deficiencies cited remains corrected and/or in compliance with the regulatory requirements. a)The DON and / or Unit Managers will maintain a log of residents on prophylactic antibiotics. The log will include pharmacist recommendations related to the use of prophylactic antibiotic and the physicians□ response. b)The DON and or Unit Managers will report on the Log / Use of Prophylactic Antibiotic Therapy monthly to the Medical Director and the Interdisciplinary Care Team in the Quality Assurance Performance Committee (QAPI) monthly X 3 for tracking and trending purposes with all follow up action determined by the QAPI Team. 4.Title of person responsible for implementing the acceptable POC. a)DON and / or Unit Managers will be responsible for the implementation of the acceptable plan of correction. 5.Dates when corrective action will be completed. The corrective action dates must be acceptable to the State. a)March 2, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 93	F 881		

run to eliminate the medication was appropriate. He stated he was going to speak with Resident #58 ' s physician.

A follow up phone interview was conducted with the Medical Director on 1/31/18 at 2:52 PM. He reported he had the facility run a list of all residents her were currently prescribed a prophylactic antibiotic. He stated there were 3 residents total (including Resident #58) who were on prophylactic antibiotics. The Medical Director indicated he expected the Antibiotic Stewardship Program to be followed.

A phone interview was conducted with Pharmacy Consultant #1 on 2/1/18 at 11:20 AM. He indicated he was currently the interim Pharmacy Consultant as the previous Pharmacy Consultant retired several months ago. He stated he was unable to recall Resident #58. The 9/1/17 NP note that indicated Resident #58 was to continue on a prophylactic antibiotic while utilizing antibiotic stewardship was reviewed with Pharmacy Consultant #1. Resident #58 ' s current physician ' s order for Bactrim that had been in place since 2/2017 was reviewed with Pharmacy Consultant #1. Pharmacy Consultant #1 stated that he imagined he would have noticed Resident #58 was on a long-term prophylactic antibiotic, but he may have not commented on it. He indicated sometimes he was dependent on prescriber ' s viewpoint in situations such as this with the use of a long-term prophylactic antibiotic.

A phone interview was conducted with Resident #58 ' s physician on 2/1/18 at 2:52 PM. The physician verified he had prescribed Bactrim as a prophylactic antibiotic for Resident #58 in 2/2017. He indicated he believed it was initially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 94 recommended by a urologist, but he was not certain of that information. He stated he had spoken with the Medical Director regarding the long-term use of prophylactic antibiotics and about the Antibiotic Stewardship Program. The physician indicated he was planning to do a trial run to eliminate the antibiotic for Resident #58 when he returned to the facility. An interview was conducted with the Director of Nursing (DON) on 2/1/18 at 12:25 PM. She stated she expected the Antibiotic Stewardship Program to be followed.	F 881		