STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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
E 000	Initial Comments A recertification survey was conducted from 07/15/19 to 07/18/19. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness, Event ID JYJJ11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted on 07/15/19 through 07/18/19. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity G. On 08/05/19 the facility was proivded with an amended 2567 report because a State Agency adminitrative review deleted tag F-655 from the report.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:	F 600		8/2/19

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

Electronically Signed | 08/08/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 1 Based on observation, record review, resident and staff interview the facility failed to protect a cognitively impaired resident from being slapped by a staff member for 1 of 1 resident investigated for staff to resident abuse (Resident #121). The findings included: Resident #121 admitted to the facility on 12/04/07 with diagnoses that included obstructive hydrocephalus, mild cognitive impairment, dementia, and others. Review of a care plan initiated on 10/09/18 read in part, Resident #121 sometimes makes inappropriate sexual advances toward staff and other residents. The goal of the care plan read, Resident #121 will not make inappropriate advances towards staff or other residents for the next 90 days. The interventions included: place resident in area where constant observation is possible during episodes of inappropriate behavior, do not argue with the resident, provide emotional support to resident and spouse when needed, monitor behavior changes, provide diversional activities, and talk with resident in a calm voice when redirecting. Review of the quarterly Minimum Data Set (MDS) dated 01/28/19 revealed Resident #121 had long and short-term memory problem and was severely impaired for daily decision making. The MDS further revealed that he required extensive to total assistance with activities of daily living. Review of an Initial Allegation Report dated 01/28/19 revealed Nursing Assistant (NA) #5 was the accused individual and the details read, reported to the supervisor by NA #6, "NA #5 was	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 2	F 600		

providing care to Resident #121 and after completion of care NA #5 was lowering the bed. Resident #121 put his hand between NA #5's legs and NA #5 struck out hitting Resident #121 and stated do not touch me." The report was signed by Nurse #2.

Review of a hand-written statement by NA #6 and dated 01/28/19 read in part, "NA #5 and I were talking about work last night and NA #5 told me she had worked with Resident #121. NA #5 stated she was providing care to Resident #121 and he put his hand on her and ran it down the front of her almost between her legs. Without thinking NA #5 hit him as hard as she could with her fist. NA #5 felt bad after she did it and had gone back later to make sure he was not bruised or hurt. NA #5 had reported to her that after she hit him, Resident #121 looked like he had saw a ghost and some people would call that abuse but he was sexually harassing her. NA #6 stated as soon as she finished the conversation with NA #5, she reported the incident to Nurse #2." The statement was signed by NA #6.

Review of a hand-written statement by NA #5 dated 01/28/19 read in part, "on Saturday 01/26/19 during our last round at 5:00 AM I was providing incontinent care to Resident #121 while my coworker was across the hall providing care to another resident. After getting Resident #121 cleaned up I was lowering his bed and I felt his hand between my legs and on reflex I smacked his hand and hollered. I told him he is not to touch me that was inappropriate and then I left the room." Signed by NA #5.

Review of an Investigation Report dated 01/29/19 read in part, the accused individual was NA #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 3	F 600		

and the Resident was Resident #121. The facility became aware of the incident on 01/28/19 at 1:10 AM. The original allegation details read in part, NA #5 had finished providing care to Resident #121 and was lowering his bed when he put his hand between her legs. NA #5 hit Resident #121's hand and stated do not touch me and reported the incident to NA #6 the following night. The report also read that after obtaining statements and discussing what occurred the facility concluded that NA #5 did strike Resident #121 after he touched her leg during care, and she was terminated effective 01/28/19. The report was signed by the Administrator.

Attempts to speak to NA #5 on 07/16/19, 07/17/19, and 07/18/19 were unsuccessful.

An interview was conducted with NA #6 on 07/16/19 at 4:04 PM. NA #6 stated that on 01/28/19 she was working with NA #5 and they were talking about work and about dementia patients. NA #6 stated that NA #5 reported to her that on the previous night she was alone in the room with Resident #121 and he had touched her inappropriately and she hit Resident #121 as hard as she could with her fist. NA #6 stated she asked NA #5 if she had reported this to anyone and she replied no. She added that NA #5 stated to her that Resident #121 took his hand and ran it down the front of her to the area between her legs and she took that as sexual harassment. NA #6 stated that she immediately left the conversation and reported what NA #5 had told her to Nurse #2. NA #5 stated that all the staff were aware that we were not to provide care to Resident #121 by ourselves because he did have the history of touching staff inappropriately but for some reason NA #5 had gone into his room that night by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 4	F 600		

herself and provided the care. NA #6 stated that when she reported it to Nurse #2 NA #5 was immediately sent home and another NA was called into finish the shift.

An observation and interview were conducted with Resident #121 on 07/17/19 at 8:54 AM. Resident #121 was sitting up in chair at bedside, he was dressed appropriately for the weather and appeared well groomed. Resident #121 was alert but non-verbal and was unable to answer any questions. Bilateral hands/arms were visible, and no bruising or redness was noted.

An interview was conducted with Nurse #2 on 07/18/19 at 9:55 AM. Nurse #2 stated that on 01/28/19 NA #6 reported that NA #5 had told her that Resident #121 grabbed her between the legs, and she punched him as hard as she could. Nurse #2 stated that when she talked to NA #5, she stated that she had punched Resident #121 in reflex of him touching her inappropriately. She stated she told NA #5 that we were never to punch or hit a resident. During that conversation NA #5 also stated that she did not mean to hit Resident #121 and she understood that she should not have struck him. Nurse #2 stated that she sent NA #5 home and reported the incident to the Administrator. Nurse #2 stated she completed the Initial Allegation Report and the Administrator had filled in the information she did not have and then faxed it to the appropriate place. Nurse #2 stated that the staff were well aware that they were not to provide care to Resident #121 alone, but regardless NA #5 should not have hit the resident.

An interview was conducted with the Director of Nursing (DON) on 07/18/19 at 4:01 PM. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 5	F 600		

stated that the Administrator handled the incident with NA #5 and Resident #121, but he had shared the information with her. The DON stated that the staff should not have been providing care to Resident #121 alone and it was never acceptable to strike or hit a resident.

An interview was conducted with the Administrator on 07/18/19 at 4:17 PM. The Administrator stated that the facility acted when NA #5 reported the incident to NA #6 and subsequently notified Nurse #2. NA #5 was immediately sent home and was not permitted to return to the facility. The Administrator stated that NA #5 should not have struck Resident #121 but did self-report the incident to NA #6. He added that NA #5's reaction was not the right reaction, but the facility followed the protocol when they were aware of the incident.

The facility provided a plan of correction. The plan of correction included: F-600:
-Nurse #2 was made aware of the incident with NA #5 and Resident #121 on 01/28/19 at 1:10 AM and spoke to NA #5. NA #5 confirmed that she had struck Resident #121.
-NA #5 was immediately removed from duty and sent home.
-Resident #121 was interviewed by the Nursing staff on 01/28/19 and could not recall the incident.
-A initial skin check for any injury to Resident #121 was conducted on 01/28/19 at 2:20 AM and no injuries were noted. The skin check was completed by Nurse #2.
-The Medical Doctor and Family were notified of the incident on 01/28/19 at 8:18 AM by Nurse #2.
-A follow up skin check was completed on Resident #121 on 01/28/19 at 7:14 PM and no injuries were noted. The skin check was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 6	F 600		

completed by Nurse #4.
-Resident #121 was evaluated by the Medical Doctor on 01/28/19.
-The Initial Allegation Report was sent to the Division of Health Service Regulation on 01/28/19 and the investigation began.
-Statements from NA #5, NA #6, and Nurse #2 were obtained on 01/28/19.
-Alert and oriented residents in the facility were interviewed and no other concerns were noted.
-Cognitively impaired residents were assessed by the nursing staff and the facility SW with no other concerns identified on 01/29/19.
-On 01/29/19 Abuse and neglect Training was given to the facility staff by the Administrator and Infection Control preventionist.
-On 01/29/19 NA #5 was reported to the Health Care Personnel Registry with no subsequent investigation completed.
-The investigation was completed and faxed to the Division of Health Service Regulation on 01/29/19.
-On 01/29/19 daily monitoring of residents began by all staff to ensure any abuse or neglect allegations were identified and diffused promptly. The daily monitoring was reported to the Administrator who is responsible for the plan of correction.
-The results of the daily monitoring were presented to the safety committee on a monthly basis and to the QA committee on a monthly basis to monitor trends and identify any other concerns and will continue to maintain compliance.
-The incident was discussed with the Quality Assurance (QA) committee during the meeting in February 2019.

The facility's plan of correction was verified during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 600	Continued From page 7 the survey 07/15/19 through 07/18/19 and included: -Resident #121 was interviewed and observed with no concerns noted. -NA #5's termination was verified. -The Initial Report was reviewed, and timely reporting was ensured. -Observation of resident care was made with no concerns identified for abuse and neglect. -Inservice records for Abuse and Neglect training were reviewed with staff signatures indicating that they had received the education. -Interviews with staff verified that they had received and understood the abuse and neglect training provided on 01/29/19. -Interviews were conducted with residents who voiced no concerns with abuse or neglect and further revealed that they were aware who and how to report any concerns to. -The facility's investigation of the incident that was reported on 01/28/19 between NA #5 and Resident #121 was reviewed which included staff statements, skin checks, resident interviews, and policy review. -The Investigation Report was reviewed, and timely reporting ensured. -Daily monitoring for abuse and neglect was reviewed with no further incidents identified. -The steps of the plan of correction were completed 01/29/19.	F 600		
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:	F 641		8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 8 Based on observations, record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) Assessments for a significant weight loss (Resident #70) and in the area of Hospitalization (Resident #128) for 2 of 6 residents reviewed for MDS assessment accuracy. The findings included: 1. Resident #70 was admitted to the facility on 01/23/19 with diagnoses that included sepsis, protein calorie malnutrition, and unspecified dementia without behavioral disturbance. A review of Resident #70's most recent Minimum Data Set (MDS) Assessment dated 05/21/19 revealed Resident #70 to be cognitively intact. Resident #70 required supervision with eating and was coded as not having had any weight loss or gain of 5% or more in the previous 30 days or 10% or more within the previous 180 days. A review of Resident #70's weights from 01/23/19 through 05/16/19 revealed Resident #70 had a recorded weight of 139.7 pounds (lbs.) on 01/23/19 and a recorded weight of 105.3 lbs. on 05/16/19. The weight differential within the 5-month time period represented a 24.67% weight loss. During an interview with MDS Nurse #1 on 07/18/19 at 4:10 PM revealed a significant weight loss should be reported on an MDS Assessment if there was 5% weight loss in 1 month or 10% weight loss in 6 months. She reported Resident #70's weight loss of 24.67% should be considered a significant weight loss and should have been appropriately coded on the MDS	F 641	1. Resident #70 and #128 both reviewed and MDS coding corrected by MDS team. 2.The MDS for residents discharged in the past 30 days will be reviewed for accuracy of discharge location. All residents with weight loss within the past 30 days will be reviewed for accuracy of coding. RD and MDS to audit and correct. 3. 10% of discharged and weight loss residents to be reviewed by DON or designee monthly x 3 months starting in September to ensure ongoing compliance. MDS team in-serviced on proper coding for weight loss and discharge location per RAI manual on 8/12/19 by DON or designee. 4. Results will be forwarded to QA for monitoring and further recommendations. DON or designee responsible. 5. Completion date 8/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 9	F 641		

Assessment dated 05/21/19. She reported the responsibility of accurately coding the weight loss fell to the facility's Clinical Nutritionist. She reported she verified each section of the MDS assessment was completed but was not responsible for verifying the information within was accurate.

During an interview with the Clinical Nutritionist on 07/18/19 at 4:57 PM, she reported she was responsible for coding significant weight loss on MDS assessments. She reported she had not coded Resident #70 with significant weight loss due to there not being a documented 5% weight loss within 30 days. She reported because Resident #70 had not been in the facility for 180 days at the time of the assessment she did not factor in the weight loss recorded up until 05/21/19. She reported it was her understanding that weights should only be looked at for the previous 30 days and exactly at 180 days for the MDS assessments and she could not use any weights prior to the 180 days.

During an interview with the Director of Nursing on 07/18/19 at 5:05 PM she reported a weight loss of 24.67% should be coded on the MDS Assessment. She stated the weight loss should have been calculated for the previous 30 days and for the entire length of Resident #70's stay, if it had been less than 6 months. She also reported it was her expectation that significant weight loss be coded accurately and in accordance with the RAI (Resident Assessment Instrument) guidelines.

2. Resident #128 was readmitted to the facility on 04/22/19 and discharged on 05/08/19.

Review of Resident #128's discharge Minimum

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 10 Data Set (MDS) assessment dated 05/08/19 revealed under Section A for Identification Information the resident was coded for A2100 for discharge to an acute hospital. Review of Resident #128's Physician Order dated 05/08/19 revealed, an order to discharge home with current medications and home health services. Review of Resident #128's Nurse's Progress Note dated 05/08/19 at 12:50 PM indicated, Resident #128 was discharged from the facility to home with his wife. During an interview with the MDS Coordinator (MDSC) on 07/18/19 at 1:42 PM she confirmed that she completed Resident #128's discharge assessment and admitted she miscode the MDS for "acute hospital" discharge instead on "Community/Home" and stated in the future she needed to be more careful. An interview was conducted with the Administrator on 07/18/19 at 3:35 PM. The Administrator stated, it was his expectation that the whole discharge process be completed and accurate which included the discharge assessment being coded to the correct destination.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 656	Continued From page 11 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a person-centered care	F 656	1. The care plan for resident #67 was corrected to reflect current immobility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 656	Continued From page 12 plan for 1 of 5 residents reviewed for the use of unnecessary medications (Resident #67). The findings included: Resident #67 was admitted to the facility on 11/13/18 with diagnoses that included spinal cord injury, muscle weakness, abnormal posture, lack of coordination, aphonia, Parkinson's disease, and anxiety among others. Resident #67's most recent significant change Minimum Data Set (MDS) Assessment dated 05/16/19 revealed Resident #67 to be moderately impaired for daily decision making and was coded as requiring extensive assistance with all activities of daily living (ADLs). Resident #67's current psychotropic medication drug care plan most recently reviewed on 05/16/19 revealed an intervention that read "observe resident's gait for steadiness, balance, muscle coordination, ability to position and turn. Document observations." During an interview with Nurse Aide (NA) #3 on 07/18/19 she reported Resident #67 required total assistance with his ADLs. She reported not being familiar with the medications that he took but that she did monitor and document his behavior. During an interview with Nurse #2 on 07/18/19 she verified that Resident #67 did not have the ability to stand or ambulate due to a spinal cord injury. During an interview with MDS Nurse #1 on 07/18/19 at 4:24 PM she reported that care plans were developed by the MDS Nurse that	F 656	2. DON or designee will audit section G of MDS for current residents to ensure all residents have proper care plans in place. Audit to be completed by 8/20/19 3. DON or designee will audit Section G for new admits x2 months to ensure compliance and QA notification. MDS team in-serviced on insuring accuracy of care plan interventions on 8/12/19 by DON or designee. 4. Results will be forwarded to QA for further recommendations and review. DON or designee responsible. 5.8/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 656	Continued From page 13 completed the assessment. She stated care plans interventions are prepopulated in the facility's electronic system for areas that "trigger" within the assessment. She reported she was aware that Resident #67 was paralyzed from neck down. She reported a care plan intervention that directed staff to monitor his gait and mobility was inappropriate and should not have been within his care plan. She stated she should have caught that and removed it from his care plan. She reported she would remove the intervention immediately and update Resident #67's care plan. During an interview with the Director of Nursing on 07/18/19 at 5:05 PM, she reported it was her expectation that resident care plans were person centered with interventions that were appropriate. She stated a care plan intervention to monitor gait and mobility for Resident #67 was inappropriate, not person centered and did not meet her expectation.	F 656		
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.	F 657		8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 14 (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. (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 reviews and staff interviews the facility failed to review and revise a care plan to include an actual fall with fracture and the intervention to wear a shoulder immobilizer for 1 of 4 residents reviewed for accidents (Resident #230). The findings included: Resident #230 was admitted to the facility on 06/07/19 with diagnoses which included atrial fibrillation, chronic obstructive pulmonary disease and wound infection. Resident #230's admission Minimum Data Set (MDS) assessment dated 06/14/19 revealed, she had intact cognition and required extensive assistance with the help from two staff for transfers. The MDS also indicated Resident #230 was only able to stabilize with the help of human assistance. Resident #230's current Care Plan (CP) dated	F 657	1. Care plan for resident #230 was updated. 2. Residents readmitted from the hospital within the past 30 days will have their care plans audited for appropriate updates on 8/13/19. 3. DON or designee to audit at random 20% of care plans monthly x 3 months for accuracy. MDS team in-serviced on 8/12/19 to properly update care plan to reflect current status by DON or designee. 4. Results will be forwarded monthly to QA for further discussion and follow up by DON or designee. 5. 8/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 15	F 657		

06/14/19 specified she was at increased risk for falls related to impaired mobility and chronic pain. One established goal for Resident #230 was that she would not experience any serious life-threatening injuries as a result of a fall for the next ninety days. The interventions included: keep call light within easy access, answer call light promptly, always keep personal items within reach, assist with transfers into and out of bed and chair as needed, and PT/OT as ordered. The care plan did not address the fall the resident experienced on 07/07/19 which resulted in a fracture or the resident's need to wear a shoulder immobilizer.

An Incident Report (IR) dated 07/07/19 explained, the nurses heard Resident #230 holler for help and went to her room to find her lying on the floor. The IR indicated Resident #230 was alert but confused and complained of right shoulder pain and was sent to the Emergency Room for evaluation. The IR stated, Resident #230 sustained a right humerus fracture which required no surgery just conservative treatment until her follow up orthopedic appointment in three weeks.

Review of an Orthopedic Consultation Report dated 07/08/19 revealed Resident #230 sustained a fall which resulted in an acute three-part right proximal humerus fracture which was to be treated with a shoulder immobilizer (sling) until physical therapy could begin in three weeks.

Resident #230 was readmitted to the facility on 07/10/19 with diagnoses which included an acute three part right proximal humerus fracture.

Observation of Resident #230 on 07/17/19 at 11:51 AM revealed, she wore a blue right

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 16 shoulder immobilizer which kept her right arm in good alignment. An interview was conducted with Minimum Data Set Coordinator (MDSC) #1 on 07/18/19 at 12:20 PM. During the interview the MDSC #1 explained, she remembered discussing Resident #230's fall in the management meeting and admitted it was her responsibility to review and revise the Resident's care plan. The MDSC confirmed that as of 07/18/19 Resident #230's current care plan had not been updated to include the actual fall on 07/07/19, resulting in the right humerus fracture or the right shoulder immobilizer that the resident was to wear daily. The MDSC stated she did not know why she had not updated the care plan because she saw Resident #230 on an almost daily basis and seeing her wear the right shoulder immobilizer should have "jarred" her memory to make sure the care plan was updated. On 07/18/19 at 3:40 PM during an interview with the Administrator he indicated he could not account for why Resident #230's care plan had not been updated but stated it was his expectation that the care plan reflected the Resident's current condition.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition	F 686		8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 17 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assess and initiate a treatment to an unstageable pressure ulcer when identified for 1 of 5 residents sampled for pressure ulcers (Resident #38). The findings included: Resident #38 was admitted to the facility on 05/22/18 with diagnoses that included: anoxic brain injury, hypertension, diabetes mellitus, anemia, and others. Review of the comprehensive Minimum Data Set (MDS) dated 04/24/19 revealed that Resident #38 was severely cognitively impaired for daily decision making and was total assistance of two staff member for bed mobility. The MDS further revealed that Resident #38 was at risk for developing pressure ulcers, but none were identified during the assessment reference period. Review of a care plan initiated on 05/06/19 read in part, Resident #38 had a potential for skin breakdown related to his history of pressure ulcer, diabetes, peripheral vascular disease, total assistance with activities of daily living, and always incontinent. The goal of the care plan read, Resident #38 will maintain intact skin integrity through the next review. The	F 686	1. 1. Resident # 38 had an assessment completed and treatment initiated on 7/17/19. The pressure ulcer has healed. 2. 100% of nurses were in-serviced on 8/5/19 regarding the process to complete an assessment and initiate a treatment at the time a wound is identified. No nurse will be permitted to return to work without the in-service. b) A 100% skin audit of all residents was conducted by DON or designee on 8/7/19. No further untreated or undocumented areas were found. 3. 20% of residents will have skin audits completed weekly x 3 months to ensure assessment and treatment initiated at the time wound identified. To be completed by DON or designee. 4. Results will be forwarded to QA for review monthly. 5. Completion date 8/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 18	F 686		

interventions included: provide treatment as ordered, pressure reducing mattress on bed, keep skin clean and dry, turn and reposition as needed to alleviate pressure and promote comfort, apply sheepskin padding over footboard (added 01/31/19), moon boots (added 01/31/19), and observe skin integrity with activity of daily living and notify nurse of any open area, bruising, rashes or any unusual swelling or nodules noted.

Review of a skin assessment dated 07/02/19 completed by the Wound Nurse (WN) revealed no pressure ulcers were present on Resident #38.

Review of Resident #38's medical record on 07/15/19 revealed no record of any current pressure ulcers.

Review of a nurses note dated 07/17/19 at 10:00 AM read in part, entry for 07/16/19: it was reported that Resident #38 "had an area on his right heel. This nurse along with another nurse looked at the heel with a flash light and there is some hyperpigmentation present. No evidence of a pressure wound. Moon boots were present on bilateral feet. Air mattress is utilized on the bed as well heels being off loaded. No evidence of breakdown on the sacrum, coccyx, or buttocks present." The note was signed by the WN.

An observation of incontinence care was made on 07/17/19 at 9:14 AM with Nursing Assistant (NA) #1 and NA #2. During incontinent care Resident #38 was resting in bed with his eye open but remained nonverbal. NA #1 and NA #2 rolled Resident #38 to his right side and on the bottom of his left foot there was a large dark almost black area that was approximately the size

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 19	F 686		

of 2 half dollars. NA #2 indicated that the area had been there a while. Resident #38 was noted to have soft boots on both feet and the foot board of his bed was covered with a sheep skin padding.

An observation of Resident #38 was made with the WN on 07/17/19 at 3:51 PM. When the area to the bottom of Resident #38's left foot was pointed out to the WN she indicated that she was unaware of the area. The WN stated that yesterday she received a note from Nurse #1 on her office door that Resident #38 had a place on his right heel, and she had gone and looked at his heels but could not find any area. The WN stated that while she was observing Resident #38's heels she also checked his sacral area, but she had not noticed the area to the bottom of his left foot "because she was focused on his heels." After she had evaluated Resident #38 and could not find any area, she threw the note away that Nurse #1 had left on her office door. During the observation NA #3 entered the room and stated that she and NA #4 had noted the black area to the bottom of Resident #38's left foot on 07/15/19 while they were giving him a shower and they had reported it to Nurse #1. During the observation the WN placed the soft boots back on Resident #38's feet and it was noted the black area was not covered by the soft boot, the area was directly above the soft boot. NA #3 pointed out that Resident #38 had a vinyl covered cushion that was placed at the end of his bed that had slipped down to the floor. When NA #3 placed the vinyl covered cushion back in place Resident #38's foot was noted to be directly flat against the vinyl covered cushion and the soft boot again did not cover the dark area on the bottom of Resident #38's left foot.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 20	F 686		

An interview was conducted with NA #3 and NA #4 on 07/17/19 at 3:55 PM. Both NAs confirmed that they noted the area to the bottom of Resident #38's left foot on 07/15/19 during his shower and had reported the area to Nurse #1.

An interview was conducted with Nurse #1 on 07/17/19 at 4:10 PM. Nurse #1 stated that on 07/15/19 NA #3 and NA #4 were giving Resident #38 a shower and they asked her to come and take look at an area they found on the bottom of his left foot. Nurse #1 stated that the area was much darker then the rest of his foot, but she was not sure what it was. She stated that she had NA #3 and #4 put lotion on him and placed a note for the WN on her office door. Nurse #1 stated that she did not initiate any treatment or do any type of assessment she had just looked at the area and left a note for the WN. Nurse #1 demonstrated the size of the area by making a large circle with her hands. She added that she did not think it was a pressure area because Resident #38 wore the soft boots on both of his feet and had sheep skin padding to his foot board.

Review of Nurse's note dated 07/17/19 at 5:19 PM read, "this nurse was requested to look at Resident #38's foot. There was a darkened area present. On 07/16/19 both feet were assessed, and this area was not observed. A full body assessment was also completed, and no new area were observed. On 07/02/19 a full body skin assessment was completed, and no new areas were observed. Preventative measures currently in place: sheep skin at the foot of the bed held in place by air mattress equipment, thick blue pad between the mattress and foot board to prevent feet from hitting foot board when he wiggles in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 21	F 686		

bed, moon boots bilaterally, knee gatch raised in an attempt to keep the resident from wiggling down in the bed and heels were offloaded with a pillow. Therapy was contacted to assess the resident for positioning (therapy had previously been consulted for current interventions). They placed gel cushions on the bottom of bilateral feet which fit on like a sock and fit underneath the moon boots. The Medical Doctor (MD) was contacted as well." The note was signed by the WN.

Review of a Wound Assessment Report dated 07/17/19 indicated that Resident #38 had a new Unstageable pressure ulcer to the left pad of his foot that was identified on 07/17/19. The measurements were 6.80 centimeters (cm) by 2.80 cm.

Review of a MD order dated 07/17/19 read, clean pad of left foot with normal saline and paint with skin prep then cover with a foam dressing every 3 days and as needed.

An interview was conducted with the Director of Nursing (DON) and the Corporate Nurse Consultant on 07/18/19 at 3:52 PM. The DON stated that the NAs found the area on the bottom of Resident #38's left foot and notified Nurse #1 and Nurse #1 left a note for the WN. She added that the WN stated the note indicated it was a right heel and Nurse #1 stated the note indicated it was the bottom of the left foot. The Corporate Nurse Consultant stated that either way the WN should have evaluated the entire foot and noted the area. The DON added that the staff should have fully assessed the area and initiated a treatment when the areas was identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 686	Continued From page 22 An interview was conducted with the Medical Director (MD) on 07/18/19 at 5:01 PM. The MD indicated "it was fairly simple he expected the staff to do everything to keep the pressure off the area." He added that he had a lot of confidence in the Nursing staff to do what they needed, and they have to keep the pressure off the area and that will keep the ulcer from developing to begin with.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Hospice Nurse and Medical Director interviews the facility failed to administer oxygen at 5 liters as prescribed for 1 of 1 resident sampled for Hospice services (Resident #63). The findings included: Resident #63 was admitted to the facility on 02/01/19 with diagnoses that included chronic obstructive pulmonary disease and heart failure. Review of a physician order dated 02/01/19 read, Oxygen at 5 liters per minute continuously.	F 695	1. Resident's oxygen was switched to a high flow concentrator with tubing immediately. Resident is non-compliant with oxygen setting and was educated and care planned for non-compliance. Resident's wife was educated on not adjusting oxygen setting. 2. All resident's requiring 5 or more liters of oxygen were switched to high flow concentrators. Nursing staff in serviced by SDC 8/9/19 on the need to use high flow concentrator for any resident at 5 liters or above. Staff were in-serviced before	8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 23 Review of the quarterly Minimum Data Set (MDS) dated 05/09/19 revealed that Resident #63 was cognitively intact and required limited assistance with activities of daily living. The MDS further revealed that Resident #63 had 6 months or less to live, required oxygen and received Hospice services. An observation and interview were conducted with Resident #63 on 07/15/19 at 3:25 PM. Resident #63 was resting in bed with eyes open. He was alert and verbal and appeared in no acute distress. He had oxygen in his nose that was connected to a concentrator that was sitting beside his bed. The concentrator was set to deliver 3.5 liters of oxygen. Resident #63 stated that he was supposed to be on 5 liters of oxygen and he was always short of breath but when lying in bed on his left side was the best position for him to get his breath and to be comfortable. An observation was made of Resident #63 on 07/16/19 at 9:17 AM. Resident #63 was resting in bed with his eyes closed. He had oxygen in his nose that was connected to a concentrator sitting next to his bed. The concentrator was set to deliver 3.5 liters of oxygen. Resident #63 appeared in no acute distress. An observation and interview were conducted with Resident #63 on 07/17/19 at 8:51 AM. Resident #63 was resting in bed with his eyes open lying on his left side. He had oxygen in his nose that was connected to a concentrator sitting next to his bed. The concentrator was set to deliver 4.5 liters of oxygen. Again Resident #63 stated he was always short of breath but no more than usual and denied any pain. Resident #63 displayed purse lipped breathing but appeared	F 695	working another shift. This training included in new hire packet for nurses. 3. The DON or designee will audit the setting on all oxygen concentrators x 3 weeks and monthly x4 months thereafter. 4. Results to be forwarded to QA monthly for recommendations on further changes as needed. DON or designee responsible. 5. 8/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 24	F 695		

comfortable and his color was normal for his ethnicity.

An interview with the Hospice Nurse (HN) was conducted on 07/17/19 at 4:39 PM. The HN stated she visited Resident #63 weekly and more often if needed. She stated that Resident #63 required 5 liters of oxygen at all times and he was generally short of breath but more on exertion. The HN stated that Resident #63 terminal diagnoses was chronic obstructive pulmonary disease and after speaking 12 to 15 words he would be short of breath and have to recover. She added that Resident #63 spent most of his time resting in bed on his left side as this was the most comfortable position for him and provided an ease of breathing. The HN again confirmed that Resident #63 required 5 liters of oxygen and she expected the facility staff to ensure that was being administered as ordered.

An observation of Resident #63 was made on 07/18/19 at 9:30 AM. Resident #63 was resting in bed with his eyes open. He had oxygen in his nose that was connected to concentrator sitting next to his bed. The concentrator was set to deliver 4.5 liters of oxygen. Resident #63 was in no acute distress and stated he had just finished his breathing treatment.

An observation and interview were conducted with Nurse #3 on 07/18/19 at 9:32 AM. Nurse #3 confirmed that she was responsible for Resident #63. She stated that Resident #63 required 5 liters of oxygen at all times and when she had checked his oxygen level earlier on the shift it was 97%. Nurse #3 observed Resident #63's oxygen concentrator and confirmed that it was set to deliver 4.5 liters and stated it should be on 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 695	Continued From page 25 liters. Nurse #3 proceed to turn the knob to 5 liters, but the dial indicator would not go to the 5-liter mark. Nurse #3 stated that for some reason that concentrator would not go up to 5 liters, but she would find one that did and get him switched over as soon as possible. She added that Resident #63 got short of breath often but more with exertion. Nurse #3 indicate that she had glanced at the concentrator earlier on the shift, but she was standing up and from that view it appeared the concentrator was set to 5 liters of oxygen but stated she should have gotten down eye level with the concentrator to clearly see what it was set to deliver. An interview was conducted with the Director of Nursing (DON) on 07/18/19 at 4:21 PM. The DON stated that the nurses should be checking the flow rate of the oxygen at least every shift and Resident #63 should receive oxygen at 5 liters as ordered. An interview was conducted with the Medical Director (MD) on 07/18/19 at 5:01 PM. The MD stated he expected oxygen to be delivered to Resident #63 as ordered.	F 695		
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	F 761		8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 26 §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 observation, record review, and staff interview the facility failed to remove expired medications from 1 of 3 medications carts reviewed during medication storage. The findings included: Review of a facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes, and Needles" read in part, facility should destroy or return all discontinued, outdated/expired medications or biologicals in accordance with the pharmacy return guidelines. An observation of the 200-hall medication cart was made on 07/18/19 at 2:58 PM with Nurse #3. Nurse #3 confirmed she was responsible for the 200-hall medication cart. A card of Calcium with Vitamin D 600 milligram (mg)/400 mg 16 tablets were found in the second drawer of the medication cart and were available for use with	F 761	1. The expired items identified by the surveyor were discarded immediately. 2. DON or designee completed 100% audit on 8/9/19 to ensure no other residents will be affected. 3. DON or designee to conduct 100% audit monthly x 2 months to ensure no issues with expired medications moving forward. DON or designee to in service all nurses on checking expiration dates of medications. Nurses in serviced before next working shift. New nurses trained on this procedure in orientation going forward. 4. Results of audit will be forwarded to QA monthly to ensure follow up and any further recommendations. DON or designee responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 27 an expiration date of 05/31/19. The expired medication was given to Nurse #3 who stated that the card of Calcium with Vitamin D was probably in the back up supply of medication and someone grabbed it and did not check the date. She confirmed that the Calcium with Vitamin D 600/400 mg that expired on 05/31/19 had been given to the resident that morning. Nurse #3 stated that she had gone through the 300 and 400 hall medication carts earlier in the week but had not gotten to the 200-hall medication cart. She stated that she was not sure who was responsible for going through the carts, but she was aware that each nurse was responsible for their own medication cart and the medication should have been pulled off the medication cart and destroyed. An interview was conducted with the Rehab Nursing Supervisor (RNS) on 07/18/19 at 3:34 PM. The RNS stated that each administrative nurse was assigned a medication storage area to go through and the calcium with vitamin D with the expiration date of 05/31/19 was just an oversight. She added that the expired medication should have been pulled off the medication cart and destroyed. An interview was conducted with the Director of Nursing (DON) on 07/18/19 at 4:06 PM. The DON stated each administrative nurse was assigned a medication storage area and each week they were to go through their assigned area. The DON stated that she expected the expired medication to be pulled off the medication cart and destroyed.	F 761	5.Compliance to be achieved by 8/20/19.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)	F 867		8/20/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 867	Continued From page 28 §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, staff, Hospice Nurse and Medical Director interviews the facilities Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in August of 2018. This was for one recited deficiency which was originally cited in July of 2018 on a recertification and complaint survey and subsequently recited in July of 2019 on the current recertification survey. The deficiency was in the area of respiratory care. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referred to F695 Respiratory Care: Based on observations, record review and resident, staff, Hospice Nurse and Medical Director interviews the facility failed to administer oxygen at 5 liters as prescribed for 1 of 1 resident sampled for Hospice services (Resident # 63). During the recertification and complaint survey of 07/13/18 the facility was cited for failure to administer oxygen at 3 liters as prescribed for 1 of 1 resident sampled for Hospice services (Resident #175). On the current recertification	F 867	1. 100% audit conducted by DON or designee on 8/9/19 of all oxygen concentrators/tanks to ensure compliance with patient orders. 2. 100% audit will be conducted by DON or designee x 4 months of all oxygen concentrators/tanks to ensure continued compliance. 3. 100 nurse in-service conducted on oxygen settings, checks and procedures by DON or designee on 8/9/19. Then quarterly thereafter. 4. Audits and in-service findings to be presented to QA monthly for review and further recommendations. 5. 8/20/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345296	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	540 WAUGH STREET JEFFERSON, NC 28640

(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 867	Continued From page 29 survey F695 was again recited for failure to administer oxygen at 5 liters as prescribed for 1 of 1 resident sampled for Hospice services. During an interview on 07/18/19 at 5:23 PM, the Administrator stated it was his expectation for oxygen liter flow to be administered according to physician's orders and monitored. He explained they had checked Resident #63's oxygen tubing and thought the tubing was too narrow and could not maximize the liter flow. He stated he expected for staff to monitor oxygen tubing to make sure it was compatible to get the correct liter flow. He further stated he expected for the Nurses to pick up on it when the oxygen liter flow was not set correctly.	F 867		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345296	A. BUILDING: _____ B. WING _____	7/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	**540 WAUGH STREET JEFFERSON, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a recapitulation (a concise summary of the course of treatment of a resident in the facility) for 1 of 3 residents reviewed for a planned discharge from the facility to the community (Resident #129). The findings included: Resident #129 was admitted to the facility on 04/18/19 which included anemia, hypothyroidism, arthritis, depression and knee replacement. Resident #129's Admission Minimum Data Set (MDS) assessment dated 04/25/19 revealed, she was cognitively intact, and she required supervision to limited assistance with her activities of daily living. The MDS also included, an active discharge goal to return to the community. Resident #129's Physician Order dated 05/04/19 revealed, an order to discharge home. Further review of Resident #129's medical record revealed, a recapitulation of the resident's stay in the facility from 04/18/19 to 05/04/19 was not completed. On 07/18/19 at 3:12 PM an interview was conducted with the Director of Nursing (DON) who admitted it was her responsibility to complete the recapitulation of the resident's stay at the facility after they were discharged. The DON confirmed she did not complete the recapitulation for Resident #129 and stated she could not offer a reason why it was not done. The DON also stated, it was her expectation to complete the discharge recapitulations after the residents' discharge from the facility.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345296	A. BUILDING: _____ B. WING _____	7/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGATE HEALTH AND REHAB CENTER	**540 WAUGH STREET JEFFERSON, NC**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 661	Continued From Page 1 During an interview with the Administrator on 07/18/19 at 3:25 PM he stated, it was his expectation for the discharge recapitulations be completed when the residents were discharged.