STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 An unannounced recertification and compliant survey was conducted 5/2/21 through 5/6/21, The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event # VGEI11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and compliant survey was conducted 5/2/21 through 5/6/21. One of the one complaint allegation was substantiated. See Event ID #VGEI11.	F 000		
F 561 SS=E	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)(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.	F 561		6/2/21

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

Electronically Signed | 05/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 1 §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 reviews, observations, and interviews with residents and staff, the facility failed to honor residents' choices related to showers. This was for 3 of 3 residents reviewed for choices (Residents #50, #59 and #87). The findings included: Cross referenced to tag: F725: Based on observation, record review, and staff and family interviews, the facility failed to have sufficient nursing staff to ensure residents received showers according to choice for 3 of 3 sampled residents (Residents #50, #59, and #87). In addition, the insufficient staffing resulted in the lack of bed baths and nail care for 2 of 5 sampled residents (Residents #19 and #64) for dependent residents. 1) Resident #50 was originally admitted to the facility on 1/4/19 with multiple diagnoses that included muscle weakness, Parkinson's disease, and chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated 4/2/21 indicated Resident #50 was cognitively intact. He required setup assistance for bathing, supervision of one person for dressing and limited assistance with personal hygiene.	F 561	This plan of correction constitutes a written allegation of compliance preparation, and submission of this plan of correction does not constitute an admission or agreement by the provider of truth of the facts alleged or the corrections of the conclusions set fourth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of the requirements under state and federal law. F561 On 5/7/21, Residents #50, #59, and #87 were interviewed by the Activity Assistant on shower preferences to include time of day, frequency, and preference of shower vs. bath. The resident choices were accommodated by changing of the shower schedules by the Director of Nursing. 100% of all in house alert and oriented residents were interviewed by the Activity Director, or Activity Assistants for shower preferences. This audit was completed on 5/10/21. For residents who are not interview able, the Responsible party was contacted by Department Managers for preferences based on responsible party recommendation. This audit was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 2 Resident #50's active care plan, last reviewed on 4/5/21, revealed problem areas for the following: - Resident required assistance from staff with Activities of Daily Living (ADL's) secondary to noted weakness and overall deconditioning with endurance deficits. The approaches included to provide assistance with ADL's, mobility and transfers as needed being careful not to overwhelm the resident. - Risk for a decline in ADL's secondary to diagnosis of Parkinson's. The approaches included to provide assistance with ADL's as needed. A review of the facility grievance logs from December 2019 till May 2021 revealed a grievance filed by Resident #50 on 4/19/21 regarding not receiving showers on a regular basis. The investigation was completed on 4/22/21 and stated the unit manager would be monitoring facility shower sheets twice a week. A review of Resident #50's medical record revealed he had scheduled showers on Tuesday and Friday on the 3:00 PM to 11:00 PM shift (2nd shift). Nursing progress notes were reviewed from 1/1/21 through 5/4/21 and did not reveal any refusals by Resident #50 for showers or bathing assistance. A review of Resident #50's Nursing Assistant (NA) bathing/shower documentation and facility shower sheets from 3/1/21 through 5/4/21 indicated Resident #50 had not received a shower on his scheduled shower days of Tuesday and Friday on 3/12/21, 3/19/21, 3/26/21, 3/30/21, 4/13/21, 4/27/21 and 4/30/21. An interview was completed with Resident #50 on	F 561	completed on 5/12/21. All necessary changes to the shower schedules were completed on 5/14/21 by the Director of Clinical Resources. On 5/10/21 an in service was initiated by the Staff Development Coordinator for documentation of showers and changes to the shower schedule. Education was also provided on residents have the right to make choices on his/her daily care needs, to include shower preference. This in service was directed to all Nurses, Certified Nursing Assistants, Medication Aides, and Personal Care Aides. The in service was completed on 5/31/21. Any staff who did not complete the in service by 5/31/21, will not be allowed to work until completed. The Director of Nursing or designee will conduct an audit weekly of 10 residents to ensure his/her shower preference is being met based on their request. This audit will be conducted weekly x 4 weeks, then monthly x 2 months. All audit results will be brought to the Quality Assurance Committee for three consecutive months, at which time, a determination will be made if further monitoring is necessary	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 3	F 561		

5/3/21 at 12:09 PM, who stated he would like to receive his scheduled showers twice a week. Resident #50 explained he had not received a shower in a few weeks and was told there wasn't enough staff, or they were too busy when he inquired about a shower. Resident #50 stated he required assistance to setup items needed for the bath as well as assistance with washing his lower legs, back and his hair and preferred to take his baths later in the evening prior to going to bed. Resident #50's hair was oily in appearance.

On 5/5/21 at 10:00 AM, an interview was conducted with Unit Manager #1 who stated if a resident refused a shower, attempts to reoffer were made and if refusals continued the NA would alert the nurse. The nurse would go and speak with the resident and document the refusal. Unit Manager #1 further stated audits were completed to ensure showers were provided as scheduled. When asked how often the audits were completed, she replied it depended on how the shift went and were supposed to be completed twice a week, however it was not consistent.

Unit Manager #2 was interviewed on 5/5/21 at 10:25 AM, who was familiar with Resident #50. Unit Manager #2 stated she was responsible for monitoring the showers received by Resident #50 since his grievance was filed and was unable to explain why showers were not provided as scheduled during the months of March and April 2021, but staffing had improved in the past month. She further stated Resident #50 preferred to have his showers later in the evening.

On 5/5/21 at 3:10 PM, an interview occurred with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 4	F 561		

Personal Care Assistant (PCA) #1 who was familiar with Resident #50 and worked the 3:00 PM to 11:00 PM shift. She couldn't recall Resident #50 refusing a shower when offered. Resident #50's shower/bath documentation was reviewed and indicated PCA #1 was assigned to the resident on 4/13/21, a scheduled shower day. She further stated Resident #50 sometimes wanted his showers at 9:30 PM which was too late to get one and might have been one of those days.

Nurse Aide #3 was interviewed on 5/5/21 at 3:27 PM, who stated she worked the 3:00 PM to 11:00 PM shift and was familiar with Resident #50. The NA stated much of the time there were only 3 aides working the 2nd shift hours making it difficult to get scheduled showers completed. NA #3 stated she was spoken to by the Administrator on 5/4/21 and was told Resident #50's word was not accurate regarding his showers. The NA added "He is alert and oriented and if he says he hasn't gotten a shower then he is probably telling the truth". She further stated she was unable to recall Resident #50 refusing scheduled showers and preferred to get them later in the evening.

On 5/5/21 at 3:59 PM an interview occurred with PCA #2 who was familiar with Resident #50. She was unable to recall Resident #50 refusing a scheduled shower when offered and preferred to receive them later in the evening. Resident #50's shower/bath documentation was reviewed and indicated PCA #2 was assigned to the resident on 4/30/21, a scheduled shower day. She further stated the staffing on 2nd shift was poor with frequent schedule changes due to last minute callouts making it difficult to give scheduled showers but was unable to state why Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 5	F 561		

#50 did not receive a shower on 4/30/21.

An interview was completed with Nurse #2 on 5/6/21 at 12:15 PM. She was familiar with Resident #50 and stated he liked to spend much of his time outside. Nurse #2 added Resident #50 liked to get his showers at or after 9:30 PM and has heard the NA's tell him they were in the middle of their last rounds at that time as well as it was too late for a shower.

The Director of Clinical Resources and Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was their expectation for showers to be provided/offered on the scheduled days. They further stated if a bed bath was provided rather than a shower the NA's documentation should indicate which was provided and the nurse should be made aware so documentation would occur in the electronic medical record as to the reason why.

2) Resident #59 was admitted to the facility on 12/7/20 with diagnoses that included a cerebral infarction (a stroke), muscle weakness and type 2 diabetes.

The quarterly Minimum Data Set (MDS) assessment dated 4/13/21 indicated Resident #59 was cognitively intact. He required extensive assistance for dressing, toileting, personal hygiene and was dependent on staff for bathing.

A review of Resident #59's active care plan, last reviewed 4/14/21, indicated a problem area of required assistance from staff with Activities of Daily Living (ADL's) related to dementia with mobility deficits, weakness and overall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 6	F 561		

deconditioning. The approaches included to provided assistance with ADL's, mobility and transfers as needed being careful not to overwhelm the resident.

A review of Resident #59's medical record revealed he had scheduled showers on Monday and Thursday on the 3:00 PM to 11:00 PM shift (2nd shift). Nursing progress notes were reviewed from 12/7/20 through 5/4/21 and did not reveal any refusals by Resident #59 for showers or personal care.

A review of Resident #59's Nursing Assistant (NA) bathing/shower documentation and facility shower sheets from 3/1/21 through 5/4/21 indicated Resident #59 had not received a shower on his scheduled shower days of Monday and Thursday on 3/1/21, 3/8/21, 3/11/21, 3/18/21, 3/22/21, 3/25/21, 3/29/21, 4/1/21, 4/8/21, 4/12/21, 4/15/21, 4/19/21, 4/22/21, 4/26/21, 4/29/21, and 5/3/21.

An interview was completed with Resident #59 on 5/5/21 at 2:45 PM, who stated he would like to receive his scheduled showers twice a week. Resident #59 explained he had not received a shower in a few weeks and was told there wasn't enough staff, or they were too busy when he inquired about a shower.

On 5/5/21 at 10:00 AM, an interview was conducted with Unit Manager #1 who stated if a resident refused a shower, attempts to reoffer were made and if refusals continued the NA would alert the nurse. The nurse would go and speak with the resident and document the refusal. Unit Manager #1 further stated audits were completed to ensure showers were provided as scheduled. When asked how often the audits

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 561		

were completed, she replied it depended on how the shift went and were supposed to be completed twice a week, however it was not consistent.

Unit Manager #2 was interviewed on 5/5/21 at 10:25 AM, who was familiar with Resident #59. Unit Manager #2 stated she was responsible for monitoring the showers and was unable to explain why showers were not provided as scheduled during the months of March and April 2021, except maybe agency staff had not documented they were provided or refused. She further stated Resident #59, sometimes preferred to have his showers later in the evening.

On 5/5/21 at 3:10 PM, an interview occurred with Personal Care Assistant (PCA) #1 who was familiar with Resident #59 and worked the 3:00 PM to 11:00 PM shift. She couldn't recall Resident #59 refusing a shower when offered and added Resident #59 sometimes wanted his showers later in the evening which was too late to get one.

Nurse Aide #3 was interviewed on 5/5/21 at 3:27 PM, who stated she worked the 3:00 PM to 11:00 PM shift and was familiar with Resident #59. The NA stated much of the time there were only 3 aides working the 2nd shift hours making it difficult to get scheduled showers completed. She further stated she was unable to recall Resident #59 refusing scheduled showers and preferred to get them later in the evening.

On 5/5/21 at 3:59 PM an interview occurred with PCA #2 who was familiar with Resident #59. She was unable to recall Resident #59 refusing a scheduled shower when offered and preferred to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 561		

receive them later in the evening. Resident #59's shower/bath documentation was reviewed and indicated PCA #2 was assigned to the resident on 4/1/21 and 4/8/21, scheduled shower days. She further stated the staffing on 2nd shift was poor with frequent schedule changes due to last minute callouts making it difficult to give scheduled showers.

An interview was completed with Nurse #2 on 5/6/21 at 10:30 AM. She was familiar with Resident #59 and stated he liked to spend much of his time outside and she was unaware of any refusals of personal care displayed by Resident #59.

The Director of Clinical Resources and Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was their expectation for showers to be provided/offered on the scheduled days. They further stated if a bed bath was provided rather than a shower the NA's documentation should indicate which was provided and the nurse should be made aware so documentation would occur in the electronic medical record as to the reason why.

3. Resident #87 was admitted 8/13/14 and readmitted on 12/4/20 with cumulative diagnoses of anxiety, Cerebral Vascular Accident (CVA) with hemiplegia on her right side and Chronic Obstructive Pulmonary Disease (COPD).

Resident #87's admission Minimum Data Set dated 12/11/20 for preferences read choosing between a shower, bed bath or sponge bath was very important to her.

Resident #87's quarterly Minimum Data Set dated 4/21/21 indicated she was cognitively intact and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 561		

she exhibited no behaviors. She was coded for physical assistance of one staff member with bathing and impairment to one side of her upper extremities.

Resident #87's care plan initiated 7/12/19 and last revised on 4/22/21 read she required assistance from staff with activities of daily living (ADL) care related to functional and mobility deficits with a history of a CVA resulting in right side hemiplegia. Interventions included staff assistance with her ADLs. Resident #87 did not have a care plan for noncompliance or refusals.

An observation and interview was conducted with Resident #87 on 5/3/21 at 2:39 PM. She was lying in bed wearing a facility gown. She stated she preferred wearing the gown for comfort. Her hair appeared unwashed and disheveled. Resident #87 stated she was able to complete a sponge bath but required staff assistance to take a shower and washing her hair. She stated she did not remember the last time she received a shower. Resident #87 stated her shower days were supposed to be Monday and Thursday's on 2nd shift. She stated the rationale the staff give her for not completing her showers was due to staffing. She stated 2nd shift would tell her there was not enough staff to assist her with a shower and say they would try to get to it later but her showers just keep getting put off. She stated her preferred method of bathing was a shower.

Review of Resident #87's electronic ADL record and hard copy shower sheets from 3/1/21 to 5/3/21 revealed evidence of 9 showers on the following days:

*3/4/21-shower
* 3/11/21-shower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 561		

*3/18/21-shower
*3/29/21-shower
*4/12/21-shower
*4/15/21-shower
*4/19/21-shower
*4/22/21-shower
*5/3/21-shower

An interview was conducted on 5/5/21 at 9:10 AM with Nursing Assistant (NA) #2. She stated she was familiar with Resident #87 and she was a 2nd shift shower resident. NA #2 stated Resident #87 never refused her showers to her knowledge because having her hair washed was very important to her.

An interview was conducted on 5/5/21 at 9:43 AM with Unit Manager (UM) #1. She stated all the UM's had a copy of the shower list and were to follow up with the aides to ensure showers were completed. UM #1 stated she audited the shower sheets and if the aides did not complete their assigned showers, she attempted to follow up with the aides prior to them leaving at 3:00 PM if she could catch them before they left. She stated she followed up with the 2nd shift aides the next day. UM #1 stated if a resident refused a shower, the aide was instructed to go back and attempt to offer a shower again. She stated she was not aware that Resident #87 was not receiving her showers as scheduled or based on her preference.

An interview was conducted on 5/5/21 at 10:25 AM with UM #2. She stated Resident #87 preferred taking a shower over a bed bath because she likes her hair to be washed. UM #2 stated the facility was using agency staff and she did not think the agency aides were completing a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 561		

shower sheet to give to the nurse. UM #2 stated the nurses put the shower sheets in the UM's box for review. She stated if a resident refuses a shower, it was the expectation that the resident's responsible party be notified. UM #2 stated the shower sheets did not take the place of the electronic ADL documentation of showers but was an extra intervention to ensure that the residents were receiving their showers as scheduled to requested.

An interview was conducted on 5/5/21 at 3:27 PM, NA #3 stated she worked on 2nd shift. She stated she was able to usually complete two showers on her shift with normally three aides working on 2nd shift. NA #3 stated Resident #87 preferred to take a shower rather than a bed bath and that she was not always able to complete Resident #87's showers on her scheduled shower days due to staffing.

Another observation and interview was conducted with Resident #87 on 5/6/21 at 10:10 AM. She was lying in bed wearing a gown. Her hair appeared clean and there was no evidence of a lack of ADL assistance. She confirmed she received a shower on Monday 5/3/21 and was supposed to get another shower today on 2nd shift. She stated at one time she was able to get a shower whenever she wanted. She stated she has history of rashes to her abdominal folds and under her breast that staff treated with a powder. Resident #87 stated she felt she needed more frequent showers due to her skin issues and based on her preferences.

An interview was conducted on 5/6/21 at 12:12 PM with Nurse #2. She stated Resident #87 was always compliant with her ADL assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 12 An interview was conducted on 5/6/21 at 3:56 PM with the Director of Nursing (DON). She stated it was her expectation that Resident #87's choice and preference for showers be honored.	F 561		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) in the areas of active diagnoses (Resident #53), prognosis and hospice (Residents #51), and for hospice (Resident #44) for 3 of 22 residents reviewed for MDS. Findings include: 1. Resident #53 was admitted on 4/23/2018 with traumatic brain injury. The FL-2 (Medicaid Program) form dated 11/12/2020 for Resident #53 had the diagnosis of paraplegia. Annual Minimum Data Set dated 4/9/2021 documented Resident #53 required extensive assist of 2 for transfers, toileting, and bathing. Active diagnosis was documented traumatic brain dysfunction. Paraplegia was not coded as an active diagnosis. The resident ' s care plan dated 7/22/2020 had a problem for one-on-one activities secondary to paraplegia	F 641	Modifications of the Minimum Data Set (MDS) for Residents #53, #51, and #44 were completed on 5/26/2021 by the MDS Nurse. 100% audit of all in house residents was completed on 5/12/21 by the Regional Reimbursement Manager to address the areas of hospice, prognosis, and active diagnoses. Any inaccuracy of assessments was modified during the audit by the MDS nurse, with a completion date of 5/26/2021. The MDS Nurse received an in-service on 5/12/2021 by the Regional Reimbursement Manager on accuracy of assessments. The Regional Reimbursement Manager or designee will review 5 Minimum Data Set (MDS) assessments and correlating documentation for accuracy weekly x 4 weeks, then 2 Minimum Data Sets (MDS) assessments and correlating	6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 13 . On 5/6/2021 at 1:40 pm an interview was conducted with the MDS Nurse. A review of the Annual MDS dated 4/9/2021 was done and she stated that the resident had the diagnosis of paraplegia and it would be added (missed). 2. Resident #51 was admitted to the facility on 2/23/2019 with cerebral vascular accident (stroke). The resident ' s care plan was updated on 4/1/2021 for initiation of hospice services. A hospice clinical note dated 4/1/2021 documented the resident ' s initiation of services and treatment plan for a decline (expected prognosis life expectancy less than 6 months). The significant change MDS dated 4/8/2021 documented the resident was severely cognitively impaired. Hospice and life expectancy of less than 6 months was not coded. On 5/6/2021 at 1:40 pm an interview was conducted with the MDS Nurse. A review of the 4/8/2021 significant change MDS dated was completed. The MDS Nurse stated that the resident had hospice services during the look back period which included prognosis less than 6 months coding and the MDS would be corrected (missed). 3. Resident # 44 was admitted to the facility on 7/1/18 with multiple diagnoses including dementia. The quarterly Minimum Data Set (MDS) assessment dated 3/31/21 indicated that Resident #44 had impaired cognition and he did	F 641	documentation weekly x 4 weeks, then 5 Minimum Data Set (MDS)assessments and correlating documentation x 1 month. The results of these audits will be brought to the Quality Assurance Committee for 3 consecutive months by the Administrator or designee, at which time, the determination will be made if further monitoring is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 14 not receive hospice care during the assessment period. Resident #44 had a doctor's order dated 3/13/21 to admit to hospice. The hospice notes revealed that Resident #44 was admitted to hospice starting 3/14/21. Interview with the MDS Nurse was conducted on 5/6/21 at 2:10 PM. The MDS Nurse verified that Resident #44 was receiving hospice care. She reviewed the quarterly MDS dated 3/31/21 and acknowledged that it was coded incorrectly in the area of hospice. She commented that she would complete a modification assessment to reflect that Resident #44 had received hospice care during the assessment period. Interview with the Director of Nursing on 5/6/21 at 4:13 PM was conducted. The DON indicated that she expected the MDS assessment to be coded accurately	F 641		
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 observations, staff and family interviews and record review, the facility failed to provide activities of daily living (ADL) assistance for residents who were dependent on staff for assistance with nail care (Resident #19) and bathing (Resident #64). This was for 2 of 5	F 677	On 5-6-21, resident #19□s nails were trimmed by the Unit Coordinator. Resident # 64 received a complete bed bath to include hair washed on 5-7-21 by the Unit Coordinator.	6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 15 residents reviewed for ADLs. The findings included: 1. Resident #19 was admitted on 1/18/18 with cumulative diagnoses of Alzheimer's Disease, Diabetes Mellitus and a left-hand contracture. Resident 19's quarterly Minimum Data Set dated 2/17/21 indicated severe cognitive impairment and she exhibited no behaviors. She was coded for extensive assistance with her personal hygiene and total assistance with bathing. She was also coded for an impairment to one side of her upper extremities. Resident #19's ADL care plan last revised 4/16/21 read she required staff assistance with the ADLs secondary to advanced age, Alzheimer's Disease, weakness and overall deconditioning. Staff were to assist Resident #19 with her ADLs. Resident #19's left hand contracture care plan last revised on 2/18/21 read staff were to observe her skin daily during routine care and report any changes to the nurse promptly. An observation of Resident #19 was conducted on 5/3/21 at 9:47 AM. She appeared clean and groomed. Her left-hand contracture was noted. Her left hand was clinched with her fingernails appearing long, dirty and jagged. Her fingernails had left a discolored indention to her left palm. Another observation of Resident #19 was completed on 5/3/21 12:00 PM. Her left-hand contracture was noted. Her left-hand fingernails appeared long, dirty and jagged. Her fingernails had left a discolored indention to her left palm. A third observation was conducted on 5/5/21 at	F 677	100% audit of all in house residents for nails was conducted on 5/14/21 by the Administrator, Admission Nurse, Social Worker and Payroll Manager. An audit of bathing schedules and documentation was conducted on 5/14/21 by the Director of Clinical resources. Any resident found to have nails that were long or jagged, were trimmed to meet his/her preference and filed. Showers schedules were revised based on resident preference on 5/14/21 and implemented on 5/17/21. On 5/10/21, an in-service was initiated by the Staff Development Coordinator for all nurses, certified nursing assistants, medication aides, and Personal care aides on nail care and showers. This in service included preferences, and documentation of showers, and nail length. This in service was completed on 5/31/2021, any staff who did not receive the in service, will not be allowed to work until complete. The Director of Nursing or designee will interview 10 residents weekly x 4 on showers/baths and nails. For residents who are not alert and oriented, a physical acknowledgement will be conducted for the audit. After 4 weeks, the audit will continue monthly x 2 months. The Director of Nursing or designee will bring these audit results to three consecutive Quality Assurance Committee meetings, at which time, a determination will be made if further monitoring is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 16	F 677		

8:30 AM. Resident #19 was lying in bed wearing a hand splint. Her fingernails still appeared long, dirty and jagged.

Resident #19's nursing notes from 3/1/21 to 5/3/21 did not include any documented noncompliance or rejection of care.

An interview was conducted on 5/5/21 at 9:10 AM with Nursing Assistant (NA) #2. She stated since Resident #19 was diabetic, it was the responsibility of the nurses to trim her fingernails. NA #2 stated the aides should report when a diabetic resident needs nail care, but she was unable to recall if she notified the nurses.

An interview was conducted on 5/5/21 at 9:55 AM with Unit Manager (UM) #1. She stated she was not aware that Resident #19 was not receiving her nail care. She stated the facility policy was for licensed nurses to complete nail care on all the diabetic residents. She further stated that members of management completed weekly rounds of the residents and rooms. She stated she was not aware of any identified management concerns during these rounds. UM #1 stated she checked in on Resident #19 earlier in the morning and ensured that her hand was cleaned, and her splint applied. She stated she did not notice that Resident #19's fingernails were still untrimmed. UM #1 stated Resident #19 was known to fight with the staff attempting to complete her ADLs and her family did not want Resident #19 to be medicated to calm down.

An interview was conducted with Nurse #2 on 5/6/21 at 12:12 PM. She stated it was the responsibility for the licensed nurses to trim diabetic resident's fingernails, but the nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 17	F 677		

relied on the aides to report the need for nail care.

An interview was conducted on 5/5/21 at 2:05 PM with Resident #19's daughter. She stated due to her mother's advanced age, if she was clean, she was satisfied with bed baths. She stated when Resident #19 was at home, she trimmed her fingernails because Resident #19 kept her hand clinched and her nails would dig into her palm. She stated it was her expectation that Resident #19's fingernails be trimmed as needed.

An interview was conducted on 5/6/21 at 3:56 PM with the Director of Nursing (DON). She stated she expected the nurses to completed Resident #19's fingernail care as needed and for the aides to notify the nurses when nail care was needed on the diabetic residents.

2. Resident #64 was admitted 10/14/19 with a neoplasm of peripheral nerves and autonomic nervous system.

Resident #64's annual Minimum Data Set dated 10/15/20 read bathing was important to her but she was unable to choose or verbalize preference. The information obtained at the time of this MDS was from family/significant other.

Resident #64's quarterly Minimum Data Set dated 4/14/21 indicated severe cognitive impairment and she exhibited no behaviors. She was coded for total assistance with bathing.

Resident #64's care plan last revised 4/15/21 read she required assistance from staff with her ADL care secondary to functional and mobility deficits. Interventions included staff assisting with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 18	F 677		

her ADLs.

Review of an undated shower schedule, Resident #64's shower days were Tuesdays and Fridays on 2nd shift.

Resident #64's electronic ADL record and hard copy shower sheets from 3/1/21 to 5/3/21 revealed evidence of showers on the following days:

*3/2/21-shower
*3/5/21-shower
*3/9/21-shower
*3/12/21-shower
*3/26/21-shower
*4/2/21-shower

Review of Resident #64's electronic ADL record from 3/1/21 to 5/3/21 revealed no evidence of a bed baths or shower on the following days: *3/3/21, 3/6/21, 3/10/21, 3/11/21, 3/13/21, 3/15/21, 3/19/21, 3/22/21, 3/25/21, 3/26/21, 3/28/21, 3/30/21, 3/31/21, 4/3/21, 4/5/21, 4/8/21 through 4/12/21, 4/18/21 through 4/22/21, 4/24/21, 4/25/21, 4/30/21 and 5/1/21.

An observation of Resident #64 was conducted on 5/3/21 at 11:20 AM. She was observed in bed. Resident #64 was nonverbal with a tracheostomy present. Her hair appeared unwashed and looked to be oily.

An interview was conducted on 5/5/21 at 9:10 AM with Nursing Assistant (NA) #2. She stated she was familiar with Resident #64 and that she required total assistance with her ADLs. NA #2 stated Resident #64 did not have a history of refusing ADL assistance and that she was scheduled for her showers on 2nd shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 19	F 677		

An interview was conducted on 5/5/21 at 9:43 AM with Unit Manager (UM) #1. She stated all the UM's had a copy of the shower list and were to follow up with the aides to ensure showers were completed. UM #1 stated she audited the shower sheets and if the aides did not complete their assigned showers, she attempted to follow up with the aides prior to them leaving at 3:00 PM if she could catch them before they left. She stated she followed up with the 2nd shift aides the next day. UM #1 stated if a resident refused a shower, the aide was instructed to go back and attempt to offer a shower again. She stated she was not aware that Resident #64 was not receiving her scheduled showers. UM #1 stated she also was not aware that Resident #64 was not receiving a bed bath daily.

An interview was conducted on 5/5/21 at 10:25 AM with UM #2. She stated the facility was using agency staff and she did not think the agency aides were completing a shower sheet to give to the nurse. UM #2 stated the nurses put the shower sheets in the UM's box for review. She stated if a resident refuses a shower, it was the expectation that the resident's responsible party be notified. UM #2 stated the shower sheets did not take the place of the electronic ADL documentation of showers but was an extra intervention to ensure that the residents were receiving their showers as scheduled to requested.

An interview was conducted on 5/5/21 at 3:11 PM with Patient Care Assistant (PCA) #1. She stated she had completed her aide training and was able to give resident showers and bed baths. PCA #1 stated she had been working at the facility for 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 20 months and she was hired during a staffing shortage. PCA #1 stated she did not assist Resident #64 because of her tracheostomy. An interview was conducted on 5/5/21 at 3:27 PM, NA #3 stated she worked on 2nd shift. She stated she normally completed two showers on her shift with usually three aides working on 2nd shift. NA #3 stated she was not always able to complete her assigned showers due to short staffing. NA #3 stated Resident #64 required total assistance with her showers and she received a bed bath on the days she did not receive her showers. An interview was conducted on 5/5/21 at 3:59 PM with PCA #2. She stated she had been checked off to perform as an aide and had worked at the facility for about 2 months. PCA #2 stated there were frequent call outs and there was no attempt to replace the person calling out. She stated she worked on 2nd shift and had to do bed baths instead of showers due to staffing. PCA #2 stated she did not attempt to shower Resident #64 but was able to assist her with a bed bath. Another observation of Resident #64 was conducted on 5/6/21 at 10:12 AM. She was lying in bed. Her hair was still damp hair from a recent shower. An interview was conducted on 5/6/21 at 3:56 PM with the Director of Nursing (DON). She stated it was her expectation that Resident #64 receive her showers as scheduled and bed baths be completed on the other days.	F 677		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 21 §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, observation and staff interview, the facility failed to determine root causes of each fall and to revise the care plan intervention after each fall (Residents #34 & #70) and also failed to put effective interventions in place following each fall to prevent repeated falls (Resident #70). This was evident for 2 of 5 sampled residents reviewed for accidents (Residents # 34 & # 70). Resident #34 ' s falls resulted in abrasions, lump, bruises, pain and emergency room (ER) evaluation. Findings included: 1. Resident #34 was admitted to the facility on 10/16/14 with multiple diagnoses including dementia with behavioral disturbances and hemiplegia/hemiparesis following cerebro vascular disease. The quarterly Minimum Data Set (MDS) assessment dated 3/3/21 indicated that Resident #34 has severe cognitive impairment and needed extensive assistance with transfers and bed mobility. The assessment further indicated that Resident #34 had falls with injury since admission/entry/reentry or prior assessment. Resident #34's care plan for falls was initiated on	F 689	Resident #34, and Resident #70, care plans were updated on 5-10-21 to reflect all interventions that remain current based on fall risk. 100% all in house residents with falls over the last 30 days were reviewed by 5/27/21 by the Director of Nursing, Assistant Director of Nursing, Unit Coordinators, MDS nurse and Director of Rehabilitation to assess for root cause, care plan intervention and an effective intervention. Any resident who was found to be missing any root cause, care plan intervention or effective intervention, were corrected by 5/27/2021. An in-service was initiated by the Staff Development Coordinator on 5-10-21 for all nurses, medication aides, Certified Nursing Assistants, and Personal Care Aides to address documentation of fall and investigation to include root cause analysis, and interventions. This in-service was completed on 5/31/2021, staff who did not complete the in services will not be allowed to work after until the in-service has been completed. The (Minimum Data	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 22 9/17/19 and was last revised on 4/20/21. The problem was "resident was at risk for falls and fall related injuries" and the goal was to minimize potential for significant injury related to falls through to next review. The approaches included to place resident in a low bed (4/15/21), fall mats to be placed to both sides of bed when the resident is in bed (4/14/21), encourage the resident to get out of bed daily as resident agrees (4/12/21) and to get the resident out of bed at appropriate time for designated smoking schedule as resident agrees (2/15/21). Resident #34's progress notes for the last 6 months were reviewed. The notes revealed that the resident had a fall with injuries on 2/24/21, 4/9/21 and 4/12/21. The progress note dated 2/24/21 at 8:00 PM (written by Nurse # 5) revealed that Resident #34 was found on the floor around 6:30 PM. The resident was found with abrasions above both eyes, a raised bump above the right eye and a bruise on the right side of lower back. The resident was reminded to ask for assistance and not to try to get out of bed alone. On 5/5/21 at 2:56 PM, Nurse #5 was interviewed. She indicated that she was assigned to Resident #34 on 2/24/21 when he fell out of bed and he sustained a laceration on his eyebrow. Nurse #5 reported that Resident #34 was cognitively impaired and was high risk for falls. His bed was in the lowest position and there were no mats on the floor during his fall. She added that the Unit Manager was responsible for the investigation and for the interventions. Review of the investigation/incident report dated 2/24/21, there was no possible root cause of the	F 689	Set) MDS Nurse was educated by the Director of Clinical Resources on 5/10/21 to ensure all interventions are documented on the care plan. The Director of Nursing and Nursing Administration were in serviced by the Director of Clinical Resources on 5/10/21, to ensure the root cause has been developed and documented on the investigation of a fall, an effective intervention has been put into place for each fall and to ensure care plans have been updated with each fall to capture each intervention. The Director of Nursing or designee with audit all documentation of falls daily x 4 weeks, then weekly x 4 weeks, then monthly x 1. The results of these audits will be brought to the Quality Assurance Committee for 3 consecutive months by the Director of Nursing or designee, at which time, the determination will be made if further monitoring is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 23	F 689		

fall documented nor intervention put into place. There was no new intervention added to the care plan after 2/24/21 fall.

The progress note dated 4/9/21 at 4:18 PM (written by the Physician Assistant) indicated that Resident #34 was seen due to a fall out of bed. He has a lump above his eyebrow on left side of his forehead. A family member was informed of the fall and was upset that the resident was in bed in afternoon and he continued to have a fall. The family member would like him to be checked for any acute infection. On examination, the resident did not show any signs of infection and he was afebrile. Laboratory works were ordered. On 5/5/21 at 12:10 PM, the Physician Assistant was interviewed. She stated that she was made aware of Resident #34 ' s falls. She reported that she had notified the family about his fall and the family wanted the resident out of bed and this was shared with the staff. She attended the falls meeting weekly and the administrative staff discussed the falls and put interventions in place, and she expected the staff to implement the interventions to prevent further falls and fall related injuries.

The progress note dated 4/9/21 at 5:01 PM (written by Nurse #1) revealed that Resident #34 was observed on the floor partially prone position with his right body on the floor mat and his forehead touching the floor. He had a bump to his left forehead and little amount of bleeding to his left wrist (old wound). On 5/4/21 at 2:45 PM, Nurse #1 was interviewed. She reported that she was assigned to Resident #34 on 4/9/21 when he had a fall. It was around 2-3 PM, she was off the floor for lunch when she was informed by NA #1 that the resident was on the floor. She went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 24	F 689		

immediately to his room and found him on the floor. There were floor mats on each side of bed, but they were small. His body was on the mat and his forehead hit the floor causing a big bump. He had an old wound to his left wrist and that was bleeding. The bed was on the lowest position. Nurse #1 further indicated that Resident #34 has cognitive impairment and was a high risk for falls. He was known to play with his bed remote control making the bed up and down. Nurse #1 reported that she came back to work on 4/13/21 and she was informed that Resident #34 had another fall on 4/12/21. He had bruises on his face and bump on his forehead. She had administered Tylenol due to signs of pain since he was unable to make his needs known. Nurse #1 added that on 4/13/21, Resident #34 had a new bed with a lock feature to prevent him from raising or lowering his bed. The Nurse reported that the Unit Manager investigated the fall and put intervention in place. On 5/5/21 at 1:50 PM, NA # 1 was interviewed. She stated that she was assigned to Resident #34 when he had a fall on 4/9/21. She indicated that she found the resident on the floor face down and he was not on the floor mat, he might have pushed the mat away from the side of the bed. He was known to play with his bed remote control, raising the bed up and down, and he was not supposed to have the remote control with him, but somebody had handed it to him. He was found with his bed not on the lowest position. He had a large bump on his left forehead.

Review of the investigation/incident report dated 4/9/21, there was no possible root cause documented. Floor mat to the right side of bed was documented on the report as intervention. There was no new intervention added to the care plan after the 4/9/21 fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 25	F 689		

The progress note dated 4/12/21 at 3:15 PM (written by Unit Manager #1) revealed that she was notified that Resident #34 was on the floor. The resident was observed on the left side of bed on the floor mat. A nurse aide (NA #5) was in the bathroom preparing to give resident a bath. Prior to the fall, the resident's bed was observed on the lowest position. On 5/4/21 at 3:05 PM, Unit Manager #1 was interviewed. She stated that she was the Unit Manager assigned to Resident #34 and she had investigated the 4/12/21 fall. She remembered that Resident #34 was found on the floor mat. She verified that the resident was found to have bruises on his face, but she had no idea what causes the bruises. She also indicated that the resident was known to play with his bed remote control, up and down, so the maintenance staff member had changed his bed after the fall on 4/12/21. This new bed had a lock feature that would allow the resident to elevate the head and foot part of the bed but would not allow him to raise the bed up and down. On 5/5/21 at 10:15 AM, NA #5 was interviewed. She stated that she was assigned to Resident #34 when he had a fall on 4/12/21. She indicated that another staff member found the resident on the floor (unable to remember the name of the staff member). She also could not remember the events of the fall (what, when, where and how). The progress note dated 4/12/21 at 4:30 PM (written by the Physician Assistant) revealed that Resident #34 had another fall with no injury. The laboratory works were ordered, and the results came back with nothing out of range. The urinalysis was still pending. A family member was called and was adamant that she did not want the resident in bed during the day and she had discussed this with the staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 26	F 689		

Review of the Medication Administration Records (MARs) revealed that Tylenol (pain reliever) was administered to Resident #34 on 4/13/21 at 8:41 AM and on 4/14/21 at 8:27 AM due to pain. The progress note dated 4/14/21 at 2:45 PM (written as late entry by Unit Manager #1) indicated that resident continued to have bruising around both eyes from the previous fall and hematoma to the left forehead.

The progress note dated 4/14/21 at 4:59 PM, (written by the Physician) revealed that Resident #34 had a fall on 4/9/21. He fell out of bed and noted to have a swelling/lump on his left forehead with some bruising. Resident had another fall out of bed on 4/12/21. Resident was seen today, sitting in wheelchair not able to hold his head up 90 degrees and his shoulder bent down. This was new today. The resident has a left forehead swelling/lump, bruising of forehead, ecchymosis around both eyes down left side of face and behind left ear to neck. Bruising in different stages, some darker areas/purplish around eyes and neck with edges more yellowish in color. The resident denied pain, but it was hard to understand him. Due to inability to lift his head up/more ecchymosis noted today, the resident was sent to the emergency room (ER) for further evaluation.

The ER records dated 4/14/21 were reviewed. The records revealed that Resident #34 presented to ER due to fall on 4/9/21 and again on 4/12/21. The resident was nonverbal but pointed to back of neck when asked about pain. The physical examination revealed resident had significant left forehead hematoma with diffuse ecchymosis throughout the forehead, intraorbitally

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 27	F 689		

bilaterally, inferior to the angle of the mandible on the left side. The assessment/plan were fall, closed head injury, facial trauma, and traumatic hematoma of forehead. The result of the Computerized Tomography (CT) of head dated 4/14/21 revealed moderate left frontal soft tissue swelling/contusion, and CT of cervical spine and maxillofacial revealed no fractures.

The progress note dated 4/15/21 at 6:38 AM revealed that Resident #34 was transferred back to the facility on 4/14/21 at 11:45 PM.

Unit Manager #1 was interviewed on 5/5/21 at 9:45 AM. She stated that she was assigned to Resident #34 when he had a fall on 2/24/21, 4/9/21 and 4/12/21. She investigated the falls and all the falls were from the bed, the resident tried to get out of bed unassisted and he was known to play with his bed remote control, raising the bed up and down. She indicated that on 4/9/21 fall, she added a floor mat to one side of bed (unable to remember if on the right or left side). When asked what interventions put in place after the 2/24/21 and 4/9/21 falls, she stated that she just started as Unit Manager.

Unit Manager (UM) #2 was interviewed on 5/5/21 at 9:50 AM. She indicated that the facility had a fall meeting once a week consisted of the Director of Nursing, Unit Managers, Staff Development Coordinator, MDS Nurse, and Therapist. They discussed the falls that week and tried to put interventions in place. She added that the facility had identified issues around March or April 2021 regarding falls investigation, not consistently documenting the root cause of the fall and the appropriate fall interventions. A plan of correction was initiated at that time and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 28	F 689		

they were still working on it. When asked about Resident #34, she stated that the root cause of the falls and the interventions should have been documented on the investigation reports, but they were not consistently documented. She also stated that the MDS Nurse should have revised the care plan to reflect new interventions after each fall. UM #2 verified that new interventions (bed change and encourage resident to be out of bed) were added after the 4/12/21 fall.

Resident #34 was observed in bed on 5/5/21 at 3:25 PM. There was a bedside table and a mat on the left side of the bed and the mat was folded in half. At 3:35 PM, NA #7 was interviewed. She stated that she was assigned to Resident #34. She explained that she folded the mat because of the bedside table on the left side of the bed. She added that this was her first assignment on the 100 hall, since she normally works in the office.

On 5/6/21 at 4:15 PM, interview with the Director of Nursing (DON) and the Director of Clinical Resources was conducted. The DON indicated that she just started as DON on 4/3/21 and not familiar with Resident #34 yet. The Director of Clinical Resources indicated that the facility had identified a problem with their fall management and provided a copy of their Quality Assurance (QA) tool. The QA tool revealed that on 4/6/21, the facility identified problems with fall interventions, documentation, follow up and neuro checks. The interventions to correct the problem included in part, all in house residents who had a fall in the last 6 months were reviewed for appropriate fall interventions and care plans and care guides were updated to show most up to date interventions and plans of care on 4/6/21. The DON, Unit Coordinators (UC), MDS Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 29	F 689		

and Director of Rehabilitation (Rehab) were in-serviced on managing fall interventions and root cause analysis of residents with falls on 4/6/21. All licensed nurses, medication aides, certified nursing assistants and patient care assistants were in-serviced on 4/6/21 on what constitutes a fall, what to do in the event of a fall and notification of falls. The DON or designee will be notified of each fall and will determine intervention necessary for resident after each fall (goal date 4/12/21 and on-going). Following business day after the fall, the DON, UC, Staff Development Coordinator (SDC), Rehab department and or MDS Nurse will ensure intervention is documented on the care plan and care guide (on-going). Weekly in the falls meeting, the DON, UC, SDC and or MDS Nurse will review all falls for the week prior, review all interventions are appropriate and reeducate staff as necessary. Any concerns identified will be addressed immediately during this meeting (initiated on 4/6/21 and on-going). Identified fall concerns will be addressed in the QA meeting no less than quarterly (goal date 7/31/21).

2. Resident #70 was admitted on 12/27/16 with cumulative diagnoses of Cerebral Vascular Accident (CVA) with left side hemiplegia and a history of falls.

Resident #70's annual Minimum Data Set (MDS) dated 4/8/21 indicated moderate cognitive impairment and he exhibited no behaviors. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 30	F 689		

was coded for limited assistance with bed mobility and transfers, walking did not occur, extensive assistance with hygiene and total assistance with toileting. Resident #70 was coded as being incontinent of bladder and bowel, impairment in mobility to side of his upper and lower extremity. He was also coded for 2 or more falls without injuries.

Resident #70's Fall Care Area Assessment dated 4/8/21 read Resident #70 had a history of falls and remained at risk for additional falls. Resident #70 had a history of a CVA with resulting left side hemiplegia, balance deficits, requiring staff assistance with all transfers. Resident #70 would however often transfer independently despite re-education and the daily use of psychotropics. His psychotropics have the potential for adverse side effects that may increase Resident #70's risk for falls, side effects of drowsiness and dizziness with visual deficits also present. Will proceed to care plan with interventions of therapy if ordered, keep call light within easy reach, answer in a timely manner, anticipate his needs as able, keep his environment well-lit and free from clutter. Additional interventions included keeping his personal items within easy reach, assisting Resident #70 with toileting, provide verbal cues for resident to not attempt to transfer without assistance, ensure Resident #70 was wearing nonskid soles for transfers, instruct and reinforce use the of assistive equipment if indicated, monitor prescribed drug use for any adverse side effects that would increase Resident #70's risk for falls.

Resident #70's falls care plan initiated 4/17/19 and last revised on 4/21/21 read he was at risk for falls and fall related injuries. The goal initiated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 31	F 689		

on 4/9/21 read to minimize potential for significant injury related to falls through to next review. Interventions included the following:
*Room rearranged to allow more space for safe transfers dated 4/20/21
* Stop sign placed on his bathroom door to remind him to call for assistance prior to attempting self-toilet or transfer dated 2/12/21
*Resident #70 was reminded and re-educated to ensure his brakes are engaged on wheelchair prior to standing and of the importance of calling for assistance with toileting and transfers dated 1/18/21
*Encourage Resident #70 to ask for assistance when retrieving items from the floor dated 12/4/20
*Remind him to ask for assistance before transferring dated 5/27/20
*Administer his medications as ordered and observe him for adverse side effects of medications in current drug regimen. Contact the Physician with abnormal findings dated 4/17/19
* Anti-tippers, anti-roll backs to his wheelchair and a brake extender to left wheelchair brake dated 11/25/19
*Anticipate his needs as able dated 4/17/19
*Assist Resident #70 with transfers as needed dated 4/17/19
* Continue to keep his environment well lit, free from clutter and potential safety hazards dated 4/17/19
* Do not move Resident #70's wheelchair from his bedside when he's is in bed as he will often transfer himself despite recommendations for assistance dated 4/17/19
* Ensure that Resident #70 has and wears properly fitting nonskid footwear for transfers dated 4/17/19
* Ensure the wheelchair wheels are locked prior to standing or transferring Resident #70.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 32	F 689		

Educate/remind him as needed dated 4/17/19
* Keep his call light within easy reach and answer his call light in a timely manner dated 4/17/19
* Observe Resident #70 for any signs and symptoms that would predispose him to falls such as change in level of consciousness, dizziness, sign or symptoms of an infection dated 4/17/19
* Orient him to new surroundings as needed dated 4/17/19
* Place frequently used items within easy reach of Resident #70 to reduce his risk of reaching for items dated 4/17/19
* Therapy to eval and treat if indicated dated 4/17/19

Review of Resident #70's fall incidents from 1/1/21 to 5/3/21 revealed a total of 10 falls:
a. 1/18/21 at 4:00 PM-Unwitnessed fall while attempting to the use toilet. The nursing note read he was calling for help and found on the bathroom floor. His wheelchair was noted outside the bathroom door with the wheels unlocked. He was wearing sneakers and the bathroom floor was not wet. He was assessed and absent of injuries. Review of the fall incident report read there were orders to initiate the fall prevention program twice daily and he monitor Resident #70 for 72 hours for bruising, change in mental status/condition, pain or other injuries related to his fall.

b. 2/15/21 at 6:45 PM-Unwitnessed fall in his room from the bed. The nursing note read he was trying to get into the wheelchair and fell. No apparent injuries, neurological (neuro) checks started and read he was on physical therapy (PT) and occupational therapy (OT) caseload for safe transfers. The incident report read the immediate intervention was rest and orders to initiate fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 33	F 689		

prevention program. Review of Resident #70's February 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff.

c. 2/21/21 at 2:00 PM-Unwitnessed fall in his room. The nursing note read Resident #70 he was lying on the floor and stated he was trying to get back into the bed. His wheelchair was at his side, wearing nonskid shoes and he was reminded to call for assistance. Neuro checks were initiated for 72 hours and a urine sample was obtained due to increased confusion. (His urinalysis returned negative for a urinary tract infection). The incident report read a Dyson pad was added to his wheelchair and the fall prevention program was initiated. Review of Resident #70's February 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff.

d. 2/28/21 at 3:52 PM-Unwitnessed fall in the hallway. The nursing note read Resident #70 was observed in the hallway sitting on his bottom in front of his wheelchair with his head against the seat of the chair. Neuro checks were initiated, and OT was to assess for a cushion device for his wheelchair. The incident report read the interventions were effective and the fall prevention program was initiated. Review of Resident #70's February 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff.

e. 3/21/21 at 1:30 PM-Unwitnessed fall in his room attempting to take his cloths out of his closet. The nursing note read staff heard a loud

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 34	F 689		

noise and went to Resident #70's room. He was taking his cloths from his closet so he could leave the facility. He had turned the wheelchair over and was lying on his left side. No injuries were noted, returned to the wheelchair and staff would continue to monitor. Review of Resident #70's MAR indicated he was administered 1 milligram of Ativan (antianxiety medication) in an injection at 2:00 PM per orders from the psychiatric Nurse Practitioner (NP). The incident report read there was no intermediate interventions, initiate fall prevention program and read this fall was reviewed in a fall committee meeting on 4/6/21. Review of Resident #70's March 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff. His March 2021 MAR also read he received one mg of Ativan in an injection at 2:00 PM.

f. 3/21/21 at 3:45 PM-Unwitnessed fall at the nursing station. The nursing note read at 3:45 PM, Resident #70 was laying on floor at nursing station on his left side with his wheelchair about 20 feet behind him. He was assisted back to into his wheelchair, taken to his room and placed in bed. His range of motion was within normal limits and he was assessed as he would allow. The incident report read the interventions were ineffective, his medication was adjusted, and he was referred to therapy for trying to walk without assistance. The fall prevention program was initiated, and the incident was reviewed in the fall committee meeting on 4/6/21. Review of Resident #70's March 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff.

g. 3/21/21 at 4:00 PM-Unwitnessed fall in his room. The nursing note read Resident #70 tried

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 35	F 689		

to walk in his room and was found lying on his left side with his wheelchair beside him. He was placed back into bed. The psychiatric NP was again notified, and a second dose of one mg Ativan was giving in another injection. The incident report read the interventions were ineffective, the fall prevention program was initiated, and the incident was reviewed in the fall committee meeting on 4/6/21. Review of Resident #70's March 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff. His March 2021 read he received a second dose of one mg of Ativan in an injection at 4:30 PM.

h. 3/21/21 at 4:30 PM-Unwitnessed fall in his room. The nursing note written at 5:45 PM read Resident #70 was status post 3 falls (3:45 PM, 4:00 PM and 4:30 PM-there was no reference to the fall at 1:30 PM). Resident #70 was noted with increased agitation and anxiety. He was up swinging arms and legs purposely trying to slid self out of his wheelchair. The dose of Ativan he was previously given with no effect. The psychiatric NP was called again and notified of increased behaviors with orders to give an additional dose of Ativan. Resident #70 continues to yell out "I am getting the hell out of here." Staff tried calling his Responsible Party (RP) and his second emergency contact to speak to Resident #70 but there was no answer at either number. Resident #70 was resting comfortably at this time, his bed was in a low position, a therapy referral was placed, medication adjusted, and staff would continue to monitor. The incident report read this fall was an isolated event and resident had increased behaviors. The evaluation note read the fall prevention program was initiated and the fall was reviewed in a fall committee meeting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 36	F 689		

4/6/21. Review of Resident #70's March 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff.

i. 3/22/21 at 12:26 AM-The incident report does not indicate if this fall was witnessed or where it occurred. The nursing note read Resident #70 was trying to transfer from the bed to his wheelchair without assistance and fell. He had no injuries and denied hitting his head. The note read staff would continue to monitor. The incident report read the fall prevention program was initiated and he was educated on requesting for help with transfers. His call light was in reach and his bed was in the low position. Review of Resident #70's March 2021 MAR included the fall prevention program twice daily and was initiated off by the nursing staff.

j. 4/20/21 at 8:25 PM-Unwitnessed fall in his room. The nursing note read Resident #70 was laying on his right side on the floor. He stated he was trying to get into the bed from his wheelchair. His wheelchair brakes were locked but the chair was very close to the bedside table leaving no room to self-transfer. Resident #70 was assessed and denied pain or injury. He sustained a skin tear and a scrap to his head where he struck his head on the bedside table. Neuro checks were initiated, the Director of Nursing was notified, and staff would continue to monitor. The incident report read his nightstand and bedside table were pulled down to give him more room to move around. The report read the intervention was effective. Resident #70 continued to self-transfer from his wheelchair to the bed and staff were to continue to encourage him to call for assistance. The fall prevention program was initiated. Review of Resident #70's April 2021 MAR included the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 37	F 689		

fall prevention program twice daily and was initiated off by the nursing staff.
Resident #70 was seen by PT from 1/18/21 to 2/18/21 for abnormal gait and weakness. His discharge summary did not include any documented evidence that his 2 falls were addressed while he was on PT caseload.

Resident #70 was seen by OT from 2/12/21 to 3/10/21 for hemiplegia, arm pain and abnormal posture. His discharge summary did not include any documented evidence that a wheelchair cushion was addressed and that his 3 falls were addressed while he was on OT caseload.

A therapy referral was made on 3/21/21 by Nurse #2 due to 4 falls while attempting to walk.

Resident #70 was seen by PT from 3/22/21 to 4/8/21 for repeated falls. His discharge summary read he was discharged to a restorative nursing program.

In an observation and interview on 5/3/21 at 2:23 PM. He was lying in bed and appeared disheveled and wearing white socks without a nonskid surface. His bed was in the normal position and his wheelchair was pushed close to his bed with the brakes locked. Resident #70 stated he was doing fine and did not need assistance from the staff to go to the bathroom.

An interview was conducted on 5/5/21 at 8:16 AM with the Director of Clinical Resources. She stated falls were discussed in the morning clinical meetings. She stated the fall incident reports were not closed out until the team had time to ensure any interventions were effective. She stated the facility started a quality improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 689		

for falls on 4/6/21. She stated the reason the fall committee was started was because the fall incidents were not thoroughly documented with a root cause analysis with effective interventions. The Director of Clinical Resources stated the fall committee met weekly and include the unit managers, the Director of Nursing (DON), MDS and therapist.

An interview was conducted on 5/5/21 at 9:15 AM with the Rehabilitation Director. He stated Resident #70's falls were reviewed daily in the morning clinical meeting and therapy would provide input as needed. He stated each incident was reviewed for documentation and that the Unit Managers (UM) had implemented the recommended interventions. The Rehabilitation Director stated the facility recently started to meet weekly to review the falls from the previous week before closing out each incident report. He stated Resident #70 was impulsive and did not understand is own limitation. He stated safeguards were put in place that on occasion do not work. He stated when Resident #70 was discharged to a restorative nursing program, it meant to nursing.

An interview was conducted on 5/5/21 at 9:43 AM with UM #1 and UM #2. UM #2 stated there should be an intervention for every fall. They stated management noted a problem in early April with the facility's response to resident falls. There was no root cause analysis of each fall and no evaluation to see if the interventions were effective. UM #2 stated that was when the weekly fall meeting started. UM #1 stated she recently became an UM when the previous UM moved to the position of Staff Development Coordinator (SDC).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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		

Another interview was conducted on 5/5/21 at 10:05 AM with UM #2. She stated where each fall incident report read the fall prevention program was initiated, she did not exactly know what that meant because she was not aware of a fall prevention program. UM #2 was unable to explain why there was no investigation, root cause analysis and no follow up to ensure the effectiveness of the interventions. She was also to explain why the was no documented evidence that nonpharmacologic interventions were attempted.

An interview was conducted on 5/5/21 at 3:27 PM with Nursing Assistant (NA) #3. She stated she was familiar with Resident #70 and that he would not listen to the staff when they reminded him to call for assistance before transferring. She stated toileting him was not one of the interventions that she was aware of because he was always incontinent. NA #3 stated she had been able to distract Resident #70 in the past with watching television.

An interview was conducted on 5/6/21 at 8:29 AM with the SDC. She stated she an UM up until the first of April 2021 and stated she was involved in the fall meetings. She stated she was not sure what was meant by the fall prevention program and the facility did not have a restorative program. When questioned about the multiple falls Resident #70 experienced in March 2021 she stated he was very agitated for some reason at that time. She stated he was not easily redirected so the psychiatric Nurse Practitioner (NP) was notified and orders were given for the 2 Ativan injections. The SDC stated she did not recall if the facility considered placing Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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		

#70 on 1:1 or implementing nonpharmacological interventions other than attempting to contact his RP. She stated she did not think any nonpharmacological interventions would have worked at that time but agreed that none were attempted.

A second observation was conducted on 5/6/21 at 10:10 AM. Resident #70 was again lying in bed. His bed was in the normal position with his wheelchair moved away from his bedside. He was wearing white socks with no nonskid surface.

An interview was conducted on 5/6/21 at 11:32 AM with the facility Physician Assistant (PA). She stated she recalled when Resident #70 had several falls, and this was not his baseline and he was not acting normally. She stated with falls, she looked for an acute infectious process as the cause first. She stated she ordered lab work and a urinalysis, but everything came back negative on Resident #70. The PA stated most of Resident #70's falls were when he tried to transfer from his wheelchair to his bed. She stated the staff and tried to educate him to no avail. She stated he had a CT scan done on 3/25/21. She stated his CT scan came back positive for pneumonia and some inflamed nodules in his lungs that would require close observation. The PA stated her practice was to discuss the use of the Ativan with the Physician to see if it was appropriate. She stated the staff would call the psychiatric NP and she often ordered Ativan. The PA stated with any agitated resident, she would expect other nonpharmacological interventions to be tried such as food, distraction or redirection.

An interview was conducted on 5/6/21 at 12:12 PM with Nurse #2. She stated the majority of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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		

Resident #70's falls occurred on her shift. She stated he was impulsive and did not realize his own limitations. She recalled on 3/21/21, he suddenly started wandering behaviors and expressed that he wasted to leave. Nurse #2 stated distractions had proven effective in the past, but she did not recall implementing any except for trying to reach his RP to help settle him down. She stated she contacted the psychiatric NP and was given orders for the one mg of injectable Ativan. She stated Resident #70 continued to act impulsively and fall so she contact the psychiatric NP again to report that the first does of Ativan was ineffective. Nurse #2 stated another dose of Ativan was ordered and given. Nurse #2 denied being short staffed at the time but recalled being short staff in February 2021 during a COVID outbreak.

A telephone interview was attempted with the psychiatry NP on 5/6/21 at 1:51 PM. A message was left for her to return the call to discuss Resident #87. There has been no return phone calls.

A telephone interview was conducted on 5/6/21 at 2:33 PM with the Consultant Pharmacist. She stated 2 mgs of Ativan was not a lot since the maximum dose was 4 mgs. She stated forgoing nonpharmacological interventions would depend on the residents and if they were a danger to themself or others.

An interview was conducted on 5/6/21 at 3:56 PM with the Director of Nursing (DON). She stated it was her expectation that Resident #70's fall interventions to be effective and include nonpharmacological interventions as well. She further stated the facility implemented a fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 committee recently to ensure there was a root cause analysis for each fall and if any interventions worked.	F 689		
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 record reviews, observations, and staff interviews, the facility failed to administer oxygen at the prescribed rate (Residents #58 and #78). This was for 2 of 2 residents reviewed for respiratory care. The findings included: 1) Resident #58 was originally admitted to the facility on 8/24/18 with multiple diagnoses that included congestive heart failure (CHF), shortness of breath, and coronary artery disease. The quarterly Minimum Data Set assessment dated 4/12/21 indicated Resident #58 had severe cognitive impairment and was dependent on staff for Activities of Daily Living. She was not coded for oxygen use. A review of Resident #58's active care plan revealed a problem area, last reviewed on	F 695	On 5/5/21, resident # 58 oxygen setting was corrected. On 5/6/21, resident #78 oxygen setting was corrected. On 5/11/21, 100% of all residents with oxygen, were audited for correct oxygen settings by the Director of Nursing and the Assistant Director of Nursing. Any resident with inaccurate settings, were corrected immediately. On 5/12/21, the Staff Development Coordinator initiated an in-service for correct oxygen settings and usage to all Nurses and Medication Aides. This in service was completed on 5/31/21, any staff who did not receive the in service will not be allowed to work until complete. The Director of Nursing or designee will audit 5 residents 3x times weekly x 4	6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 43 4/13/21, for oxygen therapy as needed to maintain oxygen saturations 90% or greater. The approaches included to administer oxygen as ordered. Review of the active physician orders revealed an order dated 4/15/21 for oxygen at 2 liters via nasal cannula continuously for respiratory distress. Titrate to keep oxygen saturations above 92%. On 5/5/21 at 11:16 AM, an observation was made of Resident #58 while she was sitting in a recliner chair in dining room area with an oxygen concentrator present and oxygen tubing on. The oxygen concentrator was turned off. An interview occurred with Nurse Aide #1 on 5/5/21 at 11:17 AM, who stated Resident #58 wore oxygen at all times. On 5/5/21 at 2:34 PM, Resident #58 was observed sitting in the dining room area in a recliner chair. The oxygen concentrator was beside her and oxygen tubing was in place. The oxygen concentrator was turned off. An observation was made with Med Aide (MA) #1 of Resident #58's oxygen concentrator on 5/5/21 at 2:55 PM. The oxygen tubing was on Resident #58 and MA #1 confirmed the oxygen concentrator was turned off. MA #1 stated the oxygen concentrator should have been turned back on when the resident was brought to the dining room area from her room. During an interview with the Director of Clinical Resources and the Director of Nursing on 5/6/21 at 4:15 PM, they indicated it was their expectation	F 695	weeks for correct oxygen settings, then weekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the Quality Assurance Committee for 3 consecutive months by the Director of Nursing, at which time, the determination will be made if further monitoring is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 44	F 695		

for oxygen to be delivered at the ordered rate.

2) Resident #78 was originally admitted to the facility on 1/11/21 with a recent readmission date of 3/29/21. Her diagnoses included chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and dilated cardiomyopathy (a condition where the heart cannot pump effectively because the left ventricle is stretched, thin and weak).

A Significant Change in Condition Minimum Data Set (MDS) assessment dated 4/26/21 revealed Resident #78 had moderately impaired cognition and received extensive to total assistance for Activities of Daily Living. She was not coded for oxygen use.

A review of Resident #78's active care plan, last reviewed 4/27/21, indicated a problem area for oxygen therapy as needed to maintain oxygen saturations of 90% or greater secondary to COPD. The approaches included to administer oxygen as ordered.

Review of the active physician orders revealed an order dated 5/3/21 to administer oxygen as needed to keep oxygen saturations greater than 92%. On 5/5/21 this order was clarified to include 2 liters of oxygen.

On 5/3/21 at 11:07 AM, an observation was made of Resident #78 which revealed the oxygen regulator on the concentrator was set at 1.5 liters flow by nasal cannula when viewed horizontally at eye level.

On 5/5/21 at 8:57 AM, an observation was made of Resident #78 while she was lying in bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 45 watching TV. The oxygen regulator on the concentrator was set at 1.5 liters flow by nasal cannula when viewed horizontally, eye level. An observation was made of Resident #78 while she was sitting in bed on 5/5/21 at 2:37 PM. The oxygen regulator on the concentrator was set at 1.5 liters flow by nasal cannula when viewed horizontally at eye level. On 5/6/21 at 10:06 AM, an observation was made of Resident #78 which revealed the oxygen regulator on the concentrator was set at 1.5 liters flow by nasal cannula when viewed horizontally at eye level. An observation was made with Unit Manager #1 of Resident #78's oxygen concentrator on 5/6/21 at 10:25 AM, who stated the oxygen regulator on the concentrator was set at 1.5 liters when viewed horizontally at eye level. Unit Manager #1 adjusted the flow to administer 2 liters of oxygen. During an interview with the Director of Clinical Resources and the Director of Nursing on 5/6/21 at 4:15 PM, they indicated it was their expectation for oxygen to be delivered at the ordered rate.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 725		6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 725	Continued From page 46 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and family interviews, the facility failed to have sufficient nursing staff to ensure residents received showers according to choice for 3 of 3 sampled residents (Residents #50, #59, and #87). In addition, the insufficient staffing resulted in the lack of bed baths and nail care for 2 of 5 sampled residents (Residents #19 and #64) for dependent residents. Findings included: Cross referenced to tag: F677: Based on observations, staff and family interviews and record review, the facility failed to provide activities of daily living (ADL) assistance for residents who were dependent on staff for assistance with nail care (Resident #19) and bathing (Resident #64). This was for 2 of 5 residents reviewed for ADLs.	F 725	The facility failed to ensure that sufficient staff was available to assist residents with showers, baths, and nail care. All residents have the potential to be affected by this practice. 100% of all licensed staff, medication aides, personal care assistants and certified nursing assistants were in-serviced on 5/10/21 by the Staff Development Coordinator in assisting with bathing and nail care as deemed necessary per resident plan of care. All licensed nursing staff, medication aides, personal care assistants and certified nursing assistants were in-serviced on notifying the Director of Nursing if the need is unable to me with the current daily staffing. These in-services were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 725	Continued From page 47 On 5/6/2021 at 1:30 pm the Staff Development Coordinator was interviewed. The SDC commented that she was not aware that residents did not receive their showers as scheduled, bed baths and nail care. The facility was using agency staff and organization criteria to staff according to census. On 5/6/2021 at 3:40 pm an interview was conducted with the Administrator. She acknowledged the reported inadequate staffing resulted in failure to provide resident ' s their showers per choice and bed baths and nail care.	F 725	completed on 5/31/21, any staff who did not receive the in service will not be allowed to work until completed. The facility will take corrective action to enhance staffing and to ensure the deficient practice does not recur with increasing coverage with use of facility staff, agency staff and utilizing the facility emergency staffing policy. The staffing coordinator will utilize nurses and certified nursing assistants for all shifts from nursing agencies, offering overtime, clinical management assistance and continuation of hiring practices until the facility has completed their interview, orientation, and training process to ensure sufficient nursing staff to provide residents with bed baths and scheduled showers and nail care as care planned. Monitoring will consist of daily Audits for 4 weeks, then weekly for 4 weeks and then monthly for one month to ensure resident needs are able to be met according to the care plan. These audits will be conducted by the Director of Nursing, Assistant Director of Nursing, or designee. The Administrator will bring the results of these audits to the Quality Assurance Committee for 3 consecutive months at which time the determination for further monitoring will be determined.	
F 756 SS=E	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		6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 48 §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 reviews, observations, and interviews with staff, Pharmacy Consultant, and facility Physician's Assistant, the Pharmacy Consultant failed to identify the facility's need to	F 756	On 5/7/21, target behaviors were added to residents #50, #58, #59, #78 and #87 orders. On 5/10/21, side effect monitoring was added to resident orders for residents	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 49	F 756		

identify target behavioral symptoms, to monitor those symptoms and the need to monitor residents for side effects of psychotropic medications (Residents #50, #58, #59, #78 and #87). In addition, the facility failed to act upon recommendations made by the Pharmacy Consultant (Resident #59). This was for 5 of 9 residents whose medications were reviewed.

The findings included:

1) Resident #50 was admitted to the facility on 1/4/19 with diagnoses that included dementia, anxiety disorder and major depression.

The quarterly Minimum Data Set (MDS) assessment dated 4/2/21 indicated Resident #50 was cognitively intact and displayed no behaviors. His mood was coded with feeling down, depressed, or hopeless as well as trouble falling asleep, staying asleep or sleeping too much 2 to 6 days during the 14 day look back period. Resident #50 received an antidepressant 7 out of 7 days of the look back period.

Resident #50's May 2021 physician orders included an order for Sertraline (an antidepressant) 150 milligrams (mg) by mouth daily for the treatment of major depression. The date of the original order for Sertraline read 2/22/21.

Review of the Consultant Pharmacist medication review notes for Resident #50 from March 2021 and April 2021 did not reflect the need for monitoring targeted behaviors.

A review of Resident #50's nursing progress notes from 2/22/21 to 5/4/21 was completed and

#50, #58, #59, #78, and #87. This was completed by the Director of Clinical Resources.

On 5/10/21, a 100% audit of all in house resident□s pharmacy recommendations for the month of April for target behaviors and side effect monitoring for residents on psychotropic medications. This was completed by 5/15/21. Any recommendation of targeted behavior or side effect monitoring that was not completed was verified with the physician and corrected by 5/15/21.

On 5/10/21, 100% audit was completed for all in house residents on psychotropic medications by the Director of Clinical Resources for documentation of targeted behaviors and side effects. Any resident who did not have documentation of targeted behaviors and side effects, was corrected at this time.
The consulting Pharmacist, on 5/26/21 completed a 100% audit on all in house residents for any psychotropic medication to ensure targeted behaviors and side effect monitoring was included on the pharmacy recommendation. All recommendations were completed by the Director of Clinical Resources on 5/27/21.

On 5/10/21, the Director of Clinical Resources in serviced the Director of Nursing, Assistant Director of Nursing, Unit Coordinators and Staff Development Coordinator on completion of pharmacy recommendations. On 5/10/21, the Staff Development Coordinator initiated an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 50 did not include documentation of any behaviors. Resident #50's Medication Administration Records (MAR's) from 3/1/21 to present indicated he received Sertraline as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff to monitor. In an observation and interview on 5/3/21 at 12:09 PM, Resident #50 was seen in his room. He appeared to be in good spirits and was engaging. He reported feelings of depression from time to time, most often when he was suffering from a headache, joint pain or when his tremors were worse. Resident #50 added he enjoyed spending much of the day outside in the courtyard. On 5/6/21 at 10:25 AM, an interview was conducted with Nurse #1, who stated there was not a specific behavior monitored for residents with psychotropic medications. A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. She further stated monitoring was accomplished with staff documentation, when present, and she would not have recommended target behaviors to be monitored on a daily basis. The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the Pharmacy Consultant to identify any irregularities regarding Resident #50's	F 756	in-service to all licensed nurses on documentation of targeted behaviors and side effects for psychotropic medications. This was completed on 5/31/21, any licensed nurse who did not receive the in service by this date, will not be allowed to work until complete. On 5/22/21, the Consulting Pharmacists Manager in serviced the Pharmacy consultant on identifying the need of target behavioral symptoms and side effects of psychotropic medications. On 5/24/21, the Facility Physician Assistant was in serviced by the Director of Clinical Resources on the need to monitor for targeted behaviors and side effects related to psychotropic medication use. The Director of Nursing or designee will audit pharmacy recommendations monthly x 3 for recommendations of monitoring targeted behaviors and side effects for residents on psychotropic medications. The Director of Nursing or designee will review resident orders for any psychotropic medication that requires targeted behaviors and side effect monitoring. This audit will be conducted daily x 4 weeks, then weekly x 4 weeks, then monthly x 1. The results of these audits will be brought to the Quality Assurance Committee for 3 consecutive months by the Director of Nursing or designee, at which time, the determination will be made if further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 51	F 756		

monitoring for targeted behavioral symptoms, effectiveness and side effects.

2) Resident #58 was originally admitted to the facility on 8/24/18 with diagnoses that included schizoaffective disorder of the depressive type, anxiety disorder, major depressive disorder, and vascular dementia with behavioral disturbance.

The quarterly Minimum Data Set (MDS) assessment dated 4/12/21 indicated Resident #58 had severe cognitive impairment, had no mood concerns, and displayed no behaviors. Resident #58 received an antidepressant 7 out of 7 days of the look back period.

Resident #58's May 2021 physician orders included an order for Sertraline (an antidepressant) 100 milligrams (mg) by mouth daily for the treatment of major depression. The date of the original order for Sertraline read 1/25/21.

Review of the Consultant Pharmacist medication review notes for Resident #58 from February 2021 to April 2021 did not reflect the need for monitoring targeted behaviors or side effects from the medication.

A review of Resident #58's nursing progress notes from 1/26/21 to 5/4/21 was completed. On 4/20/21 Resident #58 was observed picking at her skin, but no other behaviors were documented.

Resident #58's Medication Administration Records (MAR's) from 4/1/21 to present indicated she received Sertraline as ordered. The MAR did

monitoring is necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 52	F 756		

not list any targeted behaviors for staff to monitor nor side effects that may be displayed from medication use.

Resident #58 was observed on 5/3/21 at 11:10 AM, sitting up in recliner chair in no distress and without any exhibited mood or behaviors concerns.

On 5/6/21 at 10:25 AM, an interview was conducted with Nurse #1, who stated there was not a specific behavior monitored for residents with psychotropic medications and if a resident displayed a side effect, a nursing progress note should be documented. Nurse #1 added Resident #58 had episodes of restlessness where she would yell out for family members, pull the bedding off or pick at her skin.

A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. . She further stated monitoring was accomplished with staff documentation, when present, and she would not have recommended target behaviors or side effects to be monitored on a daily basis.

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM, and stated it was her expectation for the Pharmacy Consultant to identify any irregularities regarding Resident #58's monitoring for targeted behavioral symptoms, effectiveness and side effects.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 53	F 756		

3) Resident #78 was originally admitted to the facility on 1/11/21 with a recent readmission date of 3/29/21. Her diagnoses included dementia and major depressive disorder.

A Significant Change in Status Minimum Data Set (MDS) assessment dated 4/26/21 indicated Resident #78 had moderately impaired cognition and displayed had no mood concerns or behaviors. Resident #78 received an antidepressant 7 out of 7 days of the look back period.

Resident #78's May 2021 physician orders included an order for Amitriptyline (an antidepressant) 10 milligrams (mg) by mouth at bedtime, for the treatment of major depression. The date of the original order for Amitriptyline was 1/12/21.

Review of the Consultant Pharmacist medication review notes for Resident #78 from February 2021 to April 2021 did not reflect the need for monitoring targeted behaviors or side effects from the medication.

A review of Resident #78's nursing progress notes from 1/12/21 to 5/4/21 was completed and revealed no behaviors were documented.

Resident #78's Medication Administration Records (MAR's) from 3/1/21 to present indicated she received Amitriptyline as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medication use.

Resident #78 was observed on 5/3/21 at 11:07 AM, lying in her bed, without any exhibited mood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 756		

or behaviors concerns.

On 5/6/21 at 10:25 AM, an interview was conducted with Nurse #1, who stated there was not a specific behavior monitored for residents with psychotropic medications and if a resident displayed a side effect, a nursing progress note should be written. Nurse #1 added Resident #78 frequently yelled out instead of using the call light, preferred to stay in bed much of the day and could become agitated with personal care.

A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. She further stated monitoring was accomplished with staff documentation, when present, and she would not have recommended target behaviors or side effects to be monitored on a daily basis.

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the Pharmacy Consultant to identify any irregularities regarding Resident #78's monitoring for targeted behavioral symptoms, effectiveness and side effects.

4a) Resident #59 was admitted to the facility on 12/7/20 with multiple diagnoses that included major depressive disorder, mood disorder, and dementia.

The quarterly Minimum Data Set (MDS) assessment dated 4/13/21 indicated Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 756		

#59 was cognitively intact and had no mood or behavioral concerns. Resident #59 received an antidepressant 7 out of 7 days of the look back period.

Resident #59's May 2021 physician orders included an order for Lexapro (an antidepressant) 10 milligrams (mg) by mouth once a day, for the treatment of major depression. The date of the original order for Lexapro was 12/29/20.

Review of the Consultant Pharmacist medication review notes for Resident #59 from February 2021 to April 2021 did not reflect the need for monitoring targeted behaviors or side effects from the medication.

A review of Resident #59's nursing progress notes from 1/1/21 to 5/4/21 was completed and revealed on 4/14/21 an verbal altercation occurred with his roommate regarding a pair of glasses. No other behaviors were documented.

Resident #59's Medication Administration Records (MAR's) from 3/1/21 to present indicated he received Lexapro as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from the medication use.

Resident #59 was observed on 5/5/21 at 2:00 PM, up in his wheelchair. He was pleasant and talkative. There were no mood or behavioral issues noted.

On 5/6/21 at 10:20 AM an interview was completed with Nurse #2 who was familiar with Resident #59. She explained he displayed no refusals, mood, or behavioral concerns. Nurse #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 756		

stated there was not a specific behavior that was being monitored and if a resident displayed a side effect, she would write a nursing progress note.

A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. She further stated monitoring was accomplished with staff documentation, when present, and she would not have recommended target behaviors or side effects to be monitored on a daily basis.

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the Pharmacy Consultant to identify any irregularities regarding Resident #59's monitoring for targeted behavioral symptoms, effectiveness and side effects.

4b) Resident #59 was admitted to the facility on 12/7/20 with multiple diagnoses that included major depressive disorder, mood disorder, and dementia.

A pharmacy recommendation for Resident #59, dated 1/27/21 completed by the Pharmacy Consultant indicated the behaviors were to be documented cumulatively (using the number of occurrences per shift) and side effects were to be monitored for Lexapro.

The quarterly Minimum Data Set (MDS) assessment dated 4/13/21 indicated Resident #59 was cognitively intact, had no mood or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 756		

behavioral concerns. Resident #59 received an antidepressant 7 out of 7 days of the look back period.

Resident #59's May 2021 physician orders included an order for Lexapro (an antidepressant) 10 milligrams (mg) by mouth once a day, for the treatment of major depression. The date of the original order for Lexapro was 12/29/20.

Resident #59's Medication Administration Records (MAR's) from 3/1/21 to present indicated he received Lexapro as ordered. The MAR did not list any side effects that may be displayed from medication use.

On 5/6/21 at 2:26 PM, an interview occurred with Unit Manager #2 who reviewed the Pharmacy Consultant recommendation dated 1/27/21. She confirmed side effects for the use of Lexapro was not placed on the MAR as the recommendation stated and felt like it was an oversight.

A phone interview was completed with the Pharmacy Consultant on 5/6/21 at 2:38 PM. She indicated that she expected her recommendations to be responded to and/or acted upon. The pharmacy recommendation for Resident #59 dated 1/27/21 related to the need for side effect monitoring for the use of Lexapro was reviewed and the Pharmacy Consultant explained she had asked for this as Resident #59 was a new resident at the time and she didn't know his background very well. She added that she did not address the missing side effect monitoring again with the monthly medication reviews completed from February to April 2021 and verified side effects were not being monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 756		

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the facility to act upon and/or respond to pharmacy recommendations in its entirety.

5. Resident #87 was admitted 8/13/14 and readmitted on 12/4/20 with cumulative diagnoses of anxiety and Cerebral Vascular Accident (CVA).

Resident #87's quarterly Minimum Data Set dated 4/21/21 indicated she was cognitively intact and she exhibited no behaviors. She was coded as taking antianxiety and antidepressant medications for 7 of the 7 day look back.

Resident #87's care plan last revised on 4/22/21 read Resident #87 received psychotropic medications for the management of depression, insomnia and anxiety. Observe resident for any adverse side effects of medication use, document and report as indicated. Pharmacy and Physician were to monitor for the continued need for drug and psychological evaluation and follow as needed/indicated.

Resident #87's mood care plan initiated 4/29/21 read Resident #87 has signs/symptoms of mood distress: resident's brother expired. Grief counseling provided to Resident #87 and will continue PRN (as needed). Interventions included monitoring if mood endangers the resident and/or other residents and obtain a psychological consult or contact psychologist if mood is present. (The care plan did not identify mood distress or behavioral symptoms that were to be monitored).

Resident #87' May 2021 Physician orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 59	F 756		

included the following psychotropic medications:
* Ativan (antianxiety) 0.5milligrams (mg) 3 tablets at bedtime for generalized anxiety disorder dated 3/29/21
* Trazodone (antidepressant) 200 mg at bedtime for insomnia dated 12/4/20
* Effector (antidepressant) XR 24-hour release 150mg every morning for generalized anxiety disorder dated 2/9/21

Review of March, April and May 2021 Medication Administration Records (MAR) received her psychotropic medications as ordered. There was no place on the MAR identifying or to document targeted behavioral symptoms or side effect monitoring.

Review of nurse's notes for March, April, May did not include any documentation of targeted behavioral symptoms or side effect monitoring.

An undated Psychotropic Drug Therapy policy read the Consultant Pharmacist was to identify the psychotropic drugs that required side effects and target behaviors monitoring in accordance with the facility's policy. No other policies were provided by the facility.

Review of Resident #87's nursing notes from 1/1/21 to present only included one note written by the social worker dated 4/29/21 at 9:25 AM regarding the passing of her brother. The note did not provide any documentation as to what Resident #87's behavioral symptoms were at that time but read grief support provided.

A progress note completed by the psychiatric Nurse Practitioner (NP) dated 2/21/21 read Resident #87 was doing well with her insomnia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 60	F 756		

and anxiety. The note read Resident #87 was sleeping well after increasing her Ativan, the addition of melatonin and the "high" dose of Trazadone. Her mood was improved with the increase in her Effexor as requested by Resident #87 in February 2021.

A Physician Assistant (PA) progress note dated 2/22/21 read the medical indication for the visit was for follow up on psychotropic medication. The note read Resident #87 had no adverse side effects per patient/nursing. There was no reported dizziness, blurred vision, slurred speech, dyspnea, lack of coordination, new onset of confusion or drowsiness. All medications were reviewed and continued with ongoing monitoring.

The Consultant Pharmacist's monthly medication regimen review notes review from 12/4/20 to present included one recommendation dated 2/9/21 regarding the discontinuation of her Ibuprofen. It was approved on 2/19/21. There were no recommendations regarding targeted behaviors symptoms, effectiveness or side effect monitoring for Ativan, Trazadone or Effexor for Resident #87.

A progress note completed by the psychiatric NP dated 4/9/21 read Resident #87 reported she was sleeping well at night, her mood was good, and she denied any needs. Staff reported Resident #87 was doing fine with no behaviors and sleeping at night. Medications were reviewed for a possible gradual dose reduction (GDR) which was contraindicated based on her interview and examination of Resident #87 and review of available documentation. Any trial or continuance of psychotropic medications was targeted to avoid threatening, aggressive or impulsive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 61	F 756		

behaviors, likely stabilize and overall improve her quality of life.

A PA progress note dated 4/26/21 the medical indication for the visit was for follow up on psychotropic medication. The note read Resident #87 had no adverse side effects per patient/nursing. There was no reported dizziness, blurred vision, slurred speech, dyspnea, lack of coordination, new onset of confusion or drowsiness. All medications were reviewed and continued with ongoing monitoring.

An observation and interview were conducted with Resident #87 on 5/3/21 at 2:39 PM. She in bed and had not gotten up for the day yet. She was engaged in the conversation and did not display evidence of anxiety or depression. She confirmed her brother recently died and felt much better. Resident #87 endorsed occasional insomnia but denied experiencing any anxiety. She stated she was very happy that the COVID restrictions were easing.

Another observation and interview were conducted with Resident #87 on 5/6/21 at 10:15 AM. She stated she was feeling her normal self and rested well last night. She stated she has taken medications for anxiety for a very long time and that her current dose was effective. She denied any adverse side effects and stated she was seen by the psychiatric NP every few months and she always asked about her medications and how she was feeling.

An interview was conducted on 5/5/21 at 3:27 PM with Nursing Assistant (NA) #3. She stated she was familiar with Resident #87. She stated Resident #87 did not exhibit signs of anxiety like

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 62	F 756		

worry or agitation. NA #3 stated she was not exactly sure what to look for in Resident #87 but if she noted any changes in her behaviors or mood, she would report it to the nurse.

An interview was conducted with Nurse #2 on 5/6/21 at 12:12 PM. Nurse #2 stated Resident #87 had not exhibited any anxious behaviors or insomnia that she was aware of. She stated the kind of behaviors she would look for in Resident #87 would be an agitation or increased worry. Nurse #2 stated if Resident #87 was having any side effects, she would document it in a nursing note and notify the PA. Nurse #2 stated it was the facility practice to only document anything by exception and there was no identified behavioral symptoms or side effects specified for Resident #87.

An interview was conducted on 5/6/21 at 2:20 PM with Nurse #3. He stated if there weren't any orders to monitor Resident #87's behaviors or side effects, it would not populate of Resident #87's MAR for the nurses to assess. He stated he had not noticed any behaviors monitoring or side effects monitoring of any psychotropics except for antipsychotics. Nurse #3 stated he would write a nursing note if he noticed any changes in resident behavior, mood or side effects.

An interview was conducted on 5/6/21 at 2:23 PM with Nurse #6. She stated she had worked in other facilities that monitored behavioral symptoms and side effects for psychotropics. She stated she had not mentioned the lack of monitoring to anyone because she thought the Consultant Pharmacist was responsible for identifying that.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 63	F 756		

An interview was conducted on 5/6/21 at 11:32 AM with the facility PA. She stated when she wrote an order for psychotropic medications such as an antianxiety or antidepressant, she expected the facility to monitor for the resident for the effectiveness and side effects in order to support the need of the medication. She stated she considered what the resident told her and reviewed the nursing documentation when considering the need for a psychotropic medication. The PA confirmed that the expectation at the facility was for the nurses to only document any behaviors or side effects by exception. The PA stated the nursing staff were very good about letting her know if something was off with a resident. The PA also stated that the facility's psychiatric NP normally managed Resident #87's medications and monitoring.

A telephone interview was attempted with the psychiatry NP on 5/6/21 at 1:51 PM. A message was left for her to return the call to discuss Resident #87. There has been no return phone calls.

A telephone interview was conducted on 5/6/21 at 2:33 PM with the Consultant Pharmacist. She stated she deferred any psychotropic medications to the psychiatric provider. She stated she had made no recommendation regarding the need the need to identify target behavioral symptoms, effectiveness or side effects. The Consultant Pharmacist stated she reviewed the MDS, nursing notes and any psychiatric notes for any behaviors or side effects. She stated she did not expect behavior monitoring specific for Resident #87 since the facility only documented by exception.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 64 An interview was conducted on 5/6/21 at 3:56 PM with the Director of Nursing (DON). She stated it was her expectation that the Consultant Pharmacist identify any irregularities regarding Resident #87's monitoring for targeted behavioral symptoms, effectiveness and side effects. An interview was conducted on 5/6/21 at 10:30 AM with the Administrator. She stated it was not the facility practice to look for targeted behavioral symptoms or side effects but rather the nurses wrote a nursing note regarding her behaviors or side effects by exception. The Administrator stated there was no regulation requiring the need to identify target behaviors or side effects for antidepressant or antianxiety medications but only for antipsychotic medications. She stated the Consultant Pharmacist looked at the nursing notes and spoke with staff to determine any behaviors or side effects on Resident #87 and made any recommendations based on that. She stated the psychiatric NP also reviewed Resident #87's medications, nursing notes and spoke with staff about any behaviors or side effects that Resident #87 was experiencing, and the Physician reviewed her medications quarterly. She stated it was her expectation that the aides report to the nurse any unusual behaviors or side effects to follow up on.	F 756		
F 758 SS=E	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:	F 758		6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 (i) Anti-psychotic; (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	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and interviews with resident, staff, Pharmacy Consultant, and facility Physician's Assistant, the facility failed to identify target behavioral symptoms, monitor and document those symptoms. The facility also failed to monitor and document residents for side effects of psychotropic medications (Residents #50, #58, #59, #78 and #87). This was for 5 of 9 residents whose medications were reviewed. The findings included: 1. Resident #87 was admitted 8/13/14 and readmitted on 12/4/20 with cumulative diagnoses of anxiety and Cerebral Vascular Accident (CVA). Resident #87's quarterly Minimum Data Set (MDS) dated 4/21/21 indicated she was cognitively intact and she exhibited no behaviors. She was coded as taking antianxiety and antidepressant medications for 7 of the 7 day look back. Resident #87's care plan last revised on 4/22/21 read Resident #87 received psychotropic medications for the management of depression, insomnia and anxiety. Observe resident for any adverse side effects of medication use, document and report as indicated. Pharmacy and Physician were to monitor for continued need for drug and psychological evaluation and follow as needed/indicated. Resident #87's mood care plan initiated 4/29/21 read Resident #87 has signs/symptoms of mood	F 758	On 5/7/21, target behaviors were added to residents #50, #58, #59, #78 and #87 orders. On 5/10/21, side effect monitoring was added to resident orders for residents #50, #58, #59, #78, and #87. This was completed by the Director of Clinical Resources. On 5/10/21, a 100% audit of all in house resident□s pharmacy recommendations for the month of April for target behaviors and side effect monitoring for residents on psychotropic medications. This was completed by 5/15/21 by the Director of Clinical Resources. Any recommendation for targeted behavior or side effect monitoring that was not completed was verified with the physician and corrected. On 5/10/21, 100% audit was completed for all in house residents on psychotropic medications by the Director of Clinical Resources for documentation of targeted behaviors and side effects. Any resident who did not have documentation of targeted behaviors and side effects, was corrected at this time. The consulting Pharmacist, on 5/26/21 completed a 100% audit on all in house residents for any psychotropic medication to ensure targeted behaviors and side effect monitoring was included on the pharmacy recommendation. All recommendations were completed by the Director of Clinical Resources on 5/27/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 distress: resident's brother expired. Grief counseling provided to Resident #87 and will continue PRN (as needed). Interventions included monitoring if mood endangers the resident and/or other residents and obtain a psychological consult or contact psychologist if mood is present. (The care plan did not identify mood distress or behavioral symptoms that were to be monitored). Resident #87' May 2021 Physician orders included the following psychotropic medications: * Ativan (antianxiety) 0.5milligrams (mg) 3 tablets at bedtime for generalized anxiety disorder dated 3/29/21 * Trazodone (antidepressant) 200 mg at bedtime for insomnia dated 12/4/20 * Effector (antidepressant) XR 24-hour release 150mg every morning for generalized anxiety disorder dated 2/9/21 Review of March, April and May 2021 Medication Administration Records (MAR) received her psychotropic medications as ordered. There was no place on the MAR identifying or to document targeted behavioral symptoms or side effect monitoring. Review of nurse's notes for March, April, May did not include any documentation of targeted behavioral symptoms or side effect monitoring. An undated Psychotropic Drug Therapy policy read the Consultant Pharmacist was to identify the psychotropic drugs that required side effects and target behaviors monitoring in accordance with the facility's policy. No other policies were provided by the facility. Review of Resident #87's nursing notes from	F 758	On 5/10/21, the Director of Clinical Resources in serviced the Director of Nursing, Assistant Director of Nursing, Unit Coordinators and Staff Development Coordinator on completion of pharmacy recommendations. On 5/10/21, the Staff Development Coordinator initiated an in-service to all licensed nurses on documentation of targeted behaviors and side effects for psychotropic medications. This was completed on 5/31/21, any licensed nurse who did not receive the in service by this date, will not be allowed to work until complete. On 5/22/21, the Pharmacy Manager in serviced the Pharmacy consultant on identifying the need of target behavioral symptoms and side effects of psychotropic medications. On 5/24/21, the Facility Physician Assistant was in serviced by the Director of Clinical Resources on the need to monitor for targeted behaviors and side effects related to psychotropic medication use. The Director of Nursing or designee will audit pharmacy recommendations monthly x 3 for recommendations of monitoring targeted behaviors and side effects for residents on psychotropic medications. The Director of Nursing or designee will review resident orders for any psychotropic medication that requires targeted behaviors and side effect monitoring. This audit will be conducted daily x 4 weeks, then weekly x 4 weeks, then monthly x 1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 1/1/21 to present only included one note written by the social worker dated 4/29/21 at 9:25 AM regarding the passing of her brother. The note did not provide any documentation as to what Resident #87's behavioral symptoms were at that time but read grief support provided. A psychiatry progress note completed by the NP dated 2/21/21 read Resident #87 was doing well with her insomnia and anxiety. The note read Resident #87 was sleeping well after increasing her Ativan, added melatonin and high dose of Trazadone. Her mood was improved with an increase in her Effexor requested by Resident #87 in February 2021. A PA progress note dated 2/22/21 read the medical indication for the visit was for follow up on psychotropic medication. The note read Resident #87 had no adverse side effects per patient/nursing. There was no reported dizziness, blurred vision, slurred speech, dyspnea, lack of coordination, new onset of confusion or drowsiness. All medications were reviewed and continued with ongoing monitoring. The Consultant Pharmacist's monthly medication regimen review notes from 12/4/20 to present included one recommendation dated 2/9/21 regarding the discontinuation of her Ibuprofen. It was approved on 2/19/21. A psychiatry progress note completed by the psychiatric NP dated 4/9/21 read Resident #87 reported she was sleeping well at night; her mood was good, and she denied any needs. Staff reported Resident #87 was doing fine with no behaviors and sleeping at night. Medications were reviewed for a possible gradual dose	F 758	The results of these audits will be brought to the Quality Assurance Committee for 3 consecutive months by the Director of Nursing or designee, at which time, the determination will be made if further monitoring is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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		

reduction (GDR) which was contraindicated based on her interview, examination of Resident #87 and review of available documentation. Any trial or continuance of psychotropic medications were targeted to avoid threatening, aggressive or impulsive behaviors, likely stabilize and overall improve her quality of life.

A PA progress note dated 4/26/21 the medical indication for the visit was for follow up on psychotropic medication. The note read Resident #87 had no adverse side effects per patient/nursing. There was no reported dizziness, blurred vision, slurred speech, dyspnea, lack of coordination, new onset of confusion or drowsiness. All medications were reviewed and continued with ongoing monitoring.

An observation and interview were conducted with Resident #87 on 5/3/21 at 2:39 PM. She was engaged in the conversation and did not display evidence of anxiety or depression. She confirmed her brother recently died and she had done a lot of reminiscing about her brother and felt much better. Resident #87 endorsed occasional insomnia but denied experiencing any anxiety. She stated she was very happy that the COVID restrictions were easing.

Another observation and interview were conducted with Resident #87 on 5/6/21 at 10:15 AM. She in bed and had not gotten up for the day yet. Resident #87 stated she was feeling her normal and rested well last night. She stated she has taken medications for anxiety for a very long time and that her current dose was effective. She denied any adverse side effects and stated she was seen by the psychological Nurse Practitioner (NP) every few months and she always asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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	F 758		

about her medications and how she was feeling.

An interview was conducted on 5/5/21 at 3:27 PM with Nursing Assistant (NA) #3. She stated she was familiar with Resident #87. She stated Resident #87 did not exhibit signs of anxiety like worry or agitation. NA #3 stated she was not exactly sure what to look for in Resident #87 but if she noted any changes in her mood, she would report it to the nurse.

An interview was conducted with Nurse #2 on 5/6/21 at 12:12 PM. Nurse #2 stated Resident #87 had not exhibited any anxious behaviors or insomnia that she was aware of. She stated the kind of behaviors she would look for in Resident #87 would be an agitation or increased worry. Nurse #2 stated if Resident #87 was having any side effects, she would document it in a nursing note and notify the PA. Nurse #2 stated it was the facility practice to only document anything by exception and there was no identified behavioral symptoms or side effects specified for Resident #87.

An interview was conducted on 5/6/21 at 2:20 PM with Nurse #3. He stated he had not noticed any behavior monitoring or side effect monitoring of any psychotropics except for antipsychotics. He stated there wasn't a prompt for behaviors or side effect monitoring for antianxiety or antidepressant medications that he was aware of.

An interview was conducted on 5/6/21 at 2:23 PM with Nurse #6. She stated she had worked in other facilities that monitored behavioral symptoms and adverse side effects for psychotropics. She stated it was the facility expectation to document any behaviors or side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 71	F 758		

effects in a nursing note.

An interview was conducted on 5/6/21 at 11:32 AM with the Physician Assistant (PA). She stated when she wrote an order for psychotropic medications such as an antianxiety or antidepressant, she expected the facility to monitor for the resident for the effectiveness and side effects in order to support the need of the medication. She stated she considered what the resident told her and reviewed the nursing documentation when considering the need for a psychotropic medication. The PA confirmed that the expectation at the facility was for the nurses to only document any behaviors or side effects by exception. The PA stated the nursing staff was very good about letting her know if something was off with a resident. The PA also stated that the facility's psychiatric NP normally manages Resident #87's medications and monitoring.

A telephone interview was attempted with the psychiatry NP on 5/6/21 at 1:51 PM. A message was left for her to return the call to discuss Resident #87. There has been no return phone calls.

A telephone interview was conducted on 5/6/21 at 2:33 PM with the Consultant Pharmacist. She stated she deferred any psychotropic medications to the psychiatric provider. She stated she had made no recommendation regarding the need the need to identify target behavioral symptoms, effectiveness or side effects. The Consultant Pharmacist stated she reviewed the MDS, nursing notes and any psychiatric notes for any behaviors or side effects.

An interview was conducted on 5/6/21 at 3:56 PM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 72	F 758		

with the Director of Nursing (DON). She stated it was her expectation that the facility identify any irregularities regarding Resident #87's monitoring for targeted behavioral symptoms, effectiveness and side effects.

An interview was conducted on 5/6/21 at 10:30 AM with the Administrator. She stated it was not the facility practice to look for target behavioral symptoms or side effects but rather the nurses wrote a nursing note regarding her behaviors or side effects by exception. The Administrator stated there was no regulation requiring the need to identify target behaviors or side effects for antidepressant or antianxiety medications but only for antipsychotic medications. She stated the Consultant Pharmacist looked at the nursing notes and spoke with staff to determine any behaviors or side effects on Resident #87 and made any recommendations based on that. She also stated the psychiatric NP also reviewed Resident #87's medications, nursing notes and spoke with staff about any behaviors or side effects that Resident #87 was experiencing, and the Physician reviewed her medications quarterly. She stated it was her expectation that the aides report to the nurse any unusual behaviors or side effects to follow up on.

2) Resident #50 was admitted to the facility on 1/4/19 with diagnoses that included dementia, anxiety disorder and major depression.

A Social Work progress note dated 3/31/21 revealed Resident #50 reported he had sleep loss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 73	F 758		

almost daily and his depression had reduced in frequency. He displayed no behaviors other than being a hoarder and having an unkempt room.

The quarterly Minimum Data Set (MDS) assessment dated 4/2/21 indicated Resident #50 was cognitively intact and displayed no behaviors. His mood was coded with feeling down, depressed, or hopeless as well as trouble falling asleep or staying asleep or sleeping too much 2 to 6 days during the 14 day look back period. Resident #50 received an antidepressant 7 out of 7 days of the look back period.

A review of Resident #50's active care plan, last reviewed on 4/21/21, revealed the following problem areas:
- Resident has signs/symptoms of mood distress; verbalizing feeling down depressed and insomnia. The approaches included to assess if mood endangers the resident and/or other residents.
- Resident receives psychotropic medication for the diagnosis of depression and anxiety. The approaches included to administer medication as ordered and to observe for any adverse side effects of the medication use, document and report as indicated.

Resident #50's May 2021 physician orders included an order for Sertraline (an antidepressant) 150 milligrams (mg) by mouth daily for the treatment of major depression. The date of the original order for Sertraline read 2/22/21.

Review of the Consultant Pharmacist medication review notes for Resident #50 indicated the following:
- 3/16/21- no recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 74	F 758		

- 4/30/21- no recommendations.

A review of Resident #50's nursing progress notes from 1/1/21 to 5/4/21 was completed and did not include documentation of behaviors.

Resident #50's Medication Administration Records (MAR's) from 3/1/21 to present indicated he received Sertraline as ordered and exhibited no behaviors. The MAR did not list any targeted behaviors for staff to monitor.

A review of Resident #50's psychiatric progress notes indicated the following:
- 3/8/21- Resident reported his mood was down and out. Staff reported no concerns.
- 4/9/21- Resident continued to find things to worry about with no panic attacks reported by staff. Resident reported he still felt down and out.

In an observation and interview on 5/3/21 at 12:09 PM, Resident #50 was seen in his room. He appeared to be in good spirits and was engaging. He reported feelings of depression from time to time, most often when he was suffering from a headache, joint pain or when his tremors were worse. Resident #50 added he enjoyed spending much of the day outside in the courtyard.

On 5/6/21 at 10:25 AM, an interview was conducted with Nurse #1, who stated when a resident was provided their psychotropic medication there was an area on the MAR to document yes or no for behaviors present, the number of behaviors and intensity. She further stated there was not a specific behavior that was being monitored and if a resident displayed a side effect, she would write a nursing progress note.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 75	F 758		

An interview occurred with the Administrator on 5/6/21 at 10:30 AM. She explained there was no specific target behaviors or side effects that were monitored for antidepressant medications but rather the nurses would write a progress note based on the behavior or side effect exhibited. The Administrator further stated, there was not a regulation to identify target behaviors or side effects for antidepressant medications only antipsychotic medications. She added the Pharmacy Consultant and Psychiatric provider would look at notes, review medications and talk with staff to determine if there were any behaviors or side effects.

On 5/6/21 at 11:32 AM, the facility Physician's Assistant (PA) was interviewed and explained nursing staff would report if a resident was displaying behaviors or side effects to a medication. The PA added the medication would be supported by what the resident and staff report and documentation was done by exception from the nursing staff. She further stated she felt there should be some type of monitoring for specific behaviors that warranted the medication as well as side effects.

On 5/6/21 at 1:33 PM a phone call was placed to the Facility Psychiatric Nurse Practitioner. A return call was requested but was not received during the time of the survey.

Nurse #3 was interviewed on 5/6/21 at 2:20 PM and stated when a psychotropic medication was administered, an area was generated on the MAR to document yes or no for behaviors, the number of behaviors and intensity. He was not aware of anything on the MAR to document for side effects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 76	F 758		

or if there were specific behaviors for each resident.

A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. She further stated monitoring was completed on a case by case scenario and if a resident was displaying behaviors or side effects related to a psychotropic medication the nursing progress notes should reflect that.

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the staff to identify Resident #50's monitoring for targeted behavioral symptoms, effectiveness and side effects.

3) Resident #58 was originally admitted to the facility on 8/24/18 with diagnoses that included schizoaffective disorder of the depressive type, anxiety disorder, major depressive disorder, and vascular dementia with behavioral disturbance.

A Social Work progress note dated 4/12/21 revealed Resident #58 had no moods, behaviors or depression per staff report but was followed by psychiatric services for diagnoses and medication management.

The quarterly Minimum Data Set (MDS) assessment dated 4/12/21 indicated Resident #58 had severe cognitive impairment, had no mood concerns, and displayed no behaviors. Resident #58 received an antidepressant 7 out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 77	F 758		

7 days of the look back period.

A review of Resident #58's active care plan, last reviewed on 4/21/21, revealed the following problem areas:
- Resident exhibits inappropriate behaviors; resident picks at her skin. The approaches included to monitor and document resident behavior at least every shift.
- Resident receives psychotropic medications for diagnoses of dementia with behaviors, schizoaffective disorder, anorexia, and depression. The approaches included to observe resident for any adverse side effects of medication use, document and report if indicated.

Resident #58's May 2021 physician orders included an order for Sertraline (an antidepressant) 100 milligrams (mg) by mouth daily for the treatment of major depression. The date of the original order for Sertraline read 1/25/21.

Review of the Consultant Pharmacist medication review notes for Resident #58 indicated the following:
- 2/9/21- recommendation completed regarding the use of an antifungal cream.
- 3/9/21- no recommendations.
- 4/29/21- no recommendations.

A review of Resident #58's nursing progress notes from 1/1/21 to 5/4/21 was completed. On 4/20/21 Resident #58 was observed picking at her skin, but no other behaviors were documented.

Resident #58's Medication Administration Records (MARs) from 4/1/21 to present indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 78	F 758		

she received Sertraline as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from medication use.

A review of Resident #58's psychiatric progress notes indicated the following:
- 3/8/21- Resident was observed alert and calm with a smile. Staff reported she was sleeping much better with no behaviors.
- 4/13/21- Resident was observed calm and alert. Staff reported she was sleeping much of the time but with no behaviors.

Resident #58 was observed on 5/3/21 at 11:10 AM, sitting up in recliner chair in no distress and without any exhibited mood or behaviors concerns.

On 5/6/21 at 10:25 AM, an interview was conducted with Nurse #1, who stated when a resident was provided their psychotropic medication there was an area on the MAR to document yes or no for behaviors present, the number of behaviors and intensity. She further stated there was not a specific behavior that was being monitored and if a resident displayed a side effect, she would write a nursing progress note. Nurse #1 added Resident #58 had episodes of restlessness where she would yell out for family members, pull the bedding off or pick at her skin.

An interview occurred with the Administrator on 5/6/21 at 10:30 AM. She explained there was no specific target behaviors or side effects that were monitored for antidepressant medications but rather the nurses would write a progress note based on the behavior or side effect exhibited. The Administrator further stated, there was not a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 79	F 758		

regulation to identify target behaviors or side effects for antidepressant medications only antipsychotic medications. She added the Pharmacy Consultant and Psychiatric provider would look at notes, review medications and talk with staff to determine if there were any behaviors or side effects.

On 5/6/21 at 11:32 AM, the facility Physician's Assistant (PA) was interviewed and explained nursing staff would report if a resident was displaying behaviors or side effects to a medication. The PA added the medication would be supported by what the resident and staff report and documentation was done by exception from the nursing staff. She further stated she felt there should be some type of monitoring for specific behaviors that warranted the medication as well as side effects.

On 5/6/21 at 1:33 PM a phone call was placed to the Facility Psychiatric Nurse Practitioner. A return call was requested but was not received during the time of the survey.

Nurse #3 was interviewed on 5/6/21 at 2:20 PM and stated when a psychotropic medication was administered, an area was generated on the MAR to document yes or no for behaviors, the number of behaviors and intensity. He was not aware of anything on the MAR to document for side effects or if there were specific behaviors for each resident.

A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 80	F 758		

related to psychotropic medications such as antidepressants. She further stated monitoring was completed on a case by case scenario and if a resident was displaying behaviors or side effects related to a psychotropic medication the nursing progress notes should reflect that.

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the staff to identify Resident #58's monitoring for targeted behavioral symptoms, effectiveness and side effects

4) Resident #78 was originally admitted to the facility on 1/11/21 with a recent readmission date of 3/29/21. Her diagnoses included dementia and major depressive disorder.

A Social Work progress note dated 4/26/21 revealed Resident #78 denied any mood or depression concerns and had not exhibited any behaviors.

A Significant Change in Status Minimum Data Set (MDS) assessment dated 4/26/21 indicated Resident #78 had moderately impaired cognition and displayed had no mood concerns or behaviors. Resident #78 received an antidepressant 7 out of 7 days of the look back period.

A review of Resident #78's active care plan, last reviewed on 4/27/21, revealed a problem area for receives psychotropic medications to manage depression. The approaches included to observe the resident for any adverse side effects of the medication use, document and report if indicated.

Resident #78's May 2021 physician orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 81	F 758		

included an order for Amitriptyline (an antidepressant) 10 milligrams (mg) by mouth at bedtime, for the treatment of major depression. The date of the original order for Amitriptyline was 1/12/21.

Review of the Consultant Pharmacist medication review notes for Resident #78 indicated the following:
- 1/28/21- recommendations completed regarding the need for diagnoses and identification information to be added to the electronic medical record.
- 2/15/21- no recommendations.
- 3/12/21- no recommendations.
- 4/29/21- recommendations completed regarding daily supplements.

A review of Resident #78's nursing progress notes from 1/11/21 to 5/4/21 was completed and revealed no behaviors were documented.

Resident #78's Medication Administration Records (MARs) from 3/1/21 to present indicated she received Amitriptyline as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from medication use.

A review of Resident #78's psychiatric progress notes indicated the following:
- 3/6/21- Resident was observed sleeping in the bed but woke to voices and stated she was fine and sleeping at night. Staff reported she was sleeping at night, was not aggressive or combative.
- 4/6/21- Resident was observed in her bed, with cognitive impairment. She reported sleeping well and her mood was good. Staff reported she no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 82	F 758		

behaviors and was sleeping well. Nursing notes were reviewed for chronic behavioral issues with none reported.
- 4/19/21- Resident was seen sitting up in her bed, calm and alert. Stated she slept well, and mood was good. Staff reported no behaviors, slept well at night, liked to drink coffee and her appetite was poor. Nursing notes were reviewed for chronic behavioral issues with none reported.

Resident #78 was observed on 5/3/21 at 11:07 AM, lying in her bed, without any exhibited mood or behaviors concerns.

On 5/6/21 at 10:25 AM, an interview was conducted with Nurse #1, who stated when a resident was provided their psychotropic medication there was an area on the MAR to document yes or no for behaviors present, the number of behaviors and intensity. She further stated there was not a specific behavior that was being monitored and if a resident displayed a side effect, she would write a nursing progress note. Nurse #1 added Resident #78 frequently yells out instead of using the call light, prefers to stay in bed much of the day and can become agitated with personal care.

An interview occurred with the Administrator on 5/6/21 at 10:30 AM. She explained there was no specific target behaviors or side effects that were monitored for antidepressant medications but rather the nurses would write a progress note based on the behavior or side effect exhibited. The Administrator further stated, there was not a regulation to identify target behaviors or side effects for antidepressant medications only antipsychotic medications. She added the Pharmacy Consultant and Psychiatric provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 83	F 758		

would look at notes, review medications and talk with staff to determine if there were any behaviors or side effects.

On 5/6/21 at 11:32 AM, the facility Physician's Assistant (PA) was interviewed and explained nursing staff would report if a resident was displaying behaviors or side effects to a medication. The PA added the medication would be supported by what the resident and staff report and documentation was done by exception from the nursing staff. She further stated she felt there should be some type of monitoring for specific behaviors that warranted the medication as well as side effects.

On 5/6/21 at 1:33 PM a phone call was placed to the Facility Psychiatric Nurse Practitioner. A return call was requested but was not received during the time of the survey.

Nurse #3 was interviewed on 5/6/21 at 2:20 PM and stated when a psychotropic medication was administered, an area was generated on the MAR to document yes or no for behaviors, the number of behaviors and intensity. He was not aware of anything on the MAR to document for side effects or if there were specific behaviors for each resident.

A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. She further stated monitoring was completed on a case by case scenario and if a resident was displaying behaviors or side

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 84	F 758		

effects related to a psychotropic medication the nursing progress notes should reflect that.

The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the staff to identify Resident #78's monitoring for targeted behavioral symptoms, effectiveness and side effects

5) Resident #59 was admitted to the facility on 12/7/20 with multiple diagnoses that included major depressive disorder, mood disorder, and dementia.

A review of Resident #59's psychiatric progress notes indicated a progress note dated 3/22/21. The resident was seen in bed that morning and stated he was sleeping fine at night and his mood was not good. Staff reported he was good and pleasant. Nursing notes reviewed for chronic behavioral/mood issues with none reported.

A Social Work progress note dated 4/13/21 revealed Resident #59 denied any mood or depression concerns and had not exhibited any behaviors.

The quarterly Minimum Data Set (MDS) assessment dated 4/13/21 indicated Resident #59 was cognitively intact, had no mood or behavioral concerns. Resident #59 received an antidepressant 7 out of 7 days of the look back period.

A review of Resident #59's active care plan, last reviewed on 4/14/21, revealed a problem area for received a psychotropic medication to manage depression. The approaches included to observe the resident for any adverse side effects of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 85	F 758		

medication use, document and report if indicated.

Resident #59's May 2021 physician orders included an order for Lexapro (an antidepressant) 10 milligrams (mg) by mouth once a day, for the treatment of major depression. The date of the original order Lexapro was 12/29/20.

Review of the Consultant Pharmacist medication review notes for Resident #59 indicated the following:
- 1/27/21- recommendations made to ensure behaviors were documented cumulatively (using the number of occurrences per shift) and side effects were being monitored for Lexapro.
- 2/9/21- no recommendations.
- 3/12/21- no recommendations.
- 4/29/21- no recommendations.

A review of Resident #59's nursing progress notes from 1/1/21 to 5/4/21 was completed and revealed on 4/14/21 an verbal altercation occurred with roommate regarding a pair of glasses. No other behaviors were documented.

Resident #59's Medication Administration Records (MARs) from 3/1/21 to present indicated he received Lexapro as ordered. The MAR did not list any targeted behaviors for staff to monitor nor side effects that may be displayed from medication use.

Resident #59 was observed on 5/5/21 at 2:00 PM, up in his wheelchair. He was pleasant and talkative. There were no mood or behavioral issues noted.

On 5/6/21 at 10:20 AM an interview was completed with Nurse #2 who was familiar with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 86	F 758		

Resident #59. She explained he displayed no refusals, mood, or behavioral concerns. Nurse #2 explained when a resident was provided their psychotropic medication there was an area on the MAR to document yes or no for behaviors present, the number of behaviors and intensity. She further stated there was not a specific behavior that was being monitored and if a resident displayed a side effect, she would write a nursing progress note.

An interview occurred with the Administrator on 5/6/21 at 10:30 AM. She explained there was no specific target behaviors or side effects that were monitored for antidepressant medications but rather the nurses would write a progress note based on the behavior or side effect exhibited. The Administrator further stated, there was not a regulation to identify target behaviors or side effects for antidepressant medications only antipsychotic medications. She added the Pharmacy Consultant and Psychiatric provider would look at notes, review medications and talk with staff to determine if there were any behaviors or side effects.

On 5/6/21 at 11:32 AM, the facility Physician's Assistant (PA) was interviewed and explained nursing staff would report if a resident was displaying behaviors or side effects to a medication. The PA added the medication would be supported by what the resident and staff report and documentation was done by exception from the nursing staff. She further stated she felt there should be some type of monitoring for specific behaviors that warranted the medication as well as side effects.

On 5/6/21 at 1:33 PM a phone call was placed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 87 the Facility Psychiatric Nurse Practitioner. A return call was requested but was not received during the time of the survey. Nurse #3 was interviewed on 5/6/21 at 2:20 PM and stated when a psychotropic medication was administered, an area was generated on the MAR to document yes or no for behaviors, the number of behaviors and intensity. He was not aware of anything on the MAR to document for side effects or if there were specific behaviors for each resident. A telephone interview occurred with the Pharmacy Consultant on 5/6/21 at 2:38 PM, who explained she referred to nursing notes and psychiatric progress notes to monitor for specific behaviors, effectiveness and for side effects related to psychotropic medications such as antidepressants. She further stated monitoring was completed on a case by case scenario and if a resident was displaying behaviors or side effects related to a psychotropic medication the nursing progress notes should reflect that. The Director of Nursing was interviewed on 5/6/21 at 4:15 PM and stated it was her expectation for the staff to identify Resident #59's monitoring for targeted behavioral symptoms, effectiveness and side effects.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 812	Continued From page 88 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure plates and food trays were air dried and not dried with a dishtowel prior to stacking to prevent risks for cross contamination. A dietary staff also failed to wear a hairnet that covered all the hair for 1 of 5 dietary staff observed during 2 of 3 random kitchen observations (Dietary staff #2). Findings included: 1. On 5/5/21 at 1:30 PM, random kitchen observation was conducted. A dietary staff #1 was observed at the dishwasher. After the plates and the food trays were washed and rinsed at the dishwasher, the dietary staff was observed to dry the plates and the food trays with a clean dishtowel and stacked them ready for use. Dietary staff #1 was interviewed on 5/5/21 at 1:40 PM. She stated that the facility has only 1 drying rack to dry the lids and she usually dried the plates and the food trays with a dishtowel ready	F 812	On 5/5/21 Staff member #1 was observed drying plates and food trays with a clean dish towel. On 5/6/21 staff # 2 was observed wearing a scarf to cover front of head and back of head long hair was not covered. On 5/6/21 all dietary staff were in-serviced that all utensils, plates, pots, pans, trays, and cups must air dry prior to use by the Dietary Manager. On 5/6/21 all dietary staff were in-serviced on wearing hair nets in kitchen, that must cover the head of hair and not expose hair on front or back of head. Hair must be tucked in netting, by the Dietary Manager . On 5/6/21 all 10 dietary staff were in-serviced that all utensils, plates, pots, pans, trays, and cups must air dry prior to use. On 5/6/21 all 10 dietary staff were in-serviced on wearing hair nets in kitchen, that must cover the head of hair and not expose hair on front or back of head. Hair must be tucked in netting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 812	Continued From page 89 for dinner. The Dietary Manager (DM) was interviewed on 5/5/21 at 1:50 PM. The DM explained that the facility has 1 drying rack to air dry the lids and the staff were supposed to air dry the plates and the food trays on the plate and tray dishwasher racks however there was not enough space on the counter to air dry them. She added that she would order more drying racks to ensure all dishes including plates and tray were air dried. 2. On 5/6/21 at 11:30 AM, a random kitchen observation was conducted. A dietary staff #2 was observed preparing food for lunch. She has long hair with no hairnet on and she was wearing a scarf covering the hair on the front part of her head. The hair at the back of her head was exposed. Dietary staff #2 was interviewed on 5/6/21 at 1:45 PM. She stated that she wears a scarf most of the time to cover her hair. When asked about hairnet, she responded that she wore hairnet at times. The dietary staff was observed to put on a hairnet and her hair was completely covered at this time. The Dietary Manager (DM) was interviewed on 5/6/21 at 1:50 PM. She stated that she expected staff to wear a hairnet and to ensure all hair were completely covered.	F 812	The Administrator or Dietary Manager or their designee will be responsible for auditing the dietary department to ensure that items are being air dried, and that dietary staff are wearing hair nets appropriately. This audit tool will be conducted thirty times weekly for four weeks, and then 15 times weekly for four weeks and then 7 times a week for four weeks. The administrator will review these sheets weekly. The Dietary Manager or designee will present the findings to Quality Assurance Performance Improvement for three months or until a pattern of compliance is sustained	
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations	F 883		6/2/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 883	Continued From page 90	F 883		

§483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-
(i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 883	Continued From page 91 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the failed to administer pneumococcal vaccine to 1 of 5 sampled residents reviewed for immunization (Resident # 34). Findings included: Resident #34 was admitted to the facility on 10/16/14 with multiple diagnoses including chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated 3/3/21 indicated that Resident #34 had severe cognitive impairment and the pneumococcal vaccine was offered and was declined. Resident #34's immunization record revealed that on 5/13/19, the resident was offered pneumococcal vaccine and he refused/declined the vaccine. Review of Resident #34's "Pneumococcal Immunization Informed Consent" revealed that on 9/11/2019, pneumococcal vaccine was offered to the resident's responsible party (RP) and the RP	F 883	On 5/26/21, resident #34 received the pneumococcal vaccine after receiving an updated consent by the Responsible Party and physician order by the Unit Coordinator. On 5/7/21, the Administrator completed a 100% audit on all in house resident for the pneumococcal vaccine and consent. Any resident who consented for the vaccine and did not receive, a new consent was obtained and physician order to give the dose. All residents who qualified for the vaccine, received the vaccine no later than 5/26/21. On 5/10/21, the Staff Development Coordinator initiated an in service to all Licensed Nurses on vaccine consents, physician orders and giving the vaccine. This in service was completed on 5/31/21, no licensed nurse who did not receive the in service was not allowed to work until completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 05/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(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 883	Continued From page 92 had consented or had given permission to administer a pneumococcal vaccination to Resident #34. There was no record that Resident #34 had received the pneumococcal vaccine after 9/11/19. Interview with the Infection Control Nurse was conducted on 5/6/21 at 3:46 PM and she stated that she just started as Infection Control Nurse at the facility in 2020. Interview with the Unit Manager (UM) #2 was conducted on 5/6/21 at 3:48 PM. The UM verified that the RP of Resident #34 had consented to receive pneumococcal vaccine on 9/11/19 however she could not find any documentation that it was administered to the resident. She added that she could not remember the Infection Control Nurse at that time. Interview with the Director of Nursing (DON) was conducted on 5/6/21 at 4:15 PM. The DON stated that she expected the staff to administer the vaccination when the resident or RP had consented to receive the vaccine.	F 883	The Director of Nursing or designee will conduct a vaccine audit on all new admissions, daily x 4 weeks, then weekly x 4 weeks then monthly x 1. The Director of Nursing or designee will bring the results OF these audits to three consecutive Quality Assurance Committee meetings, at which time, the determination will made if further monitoring is necessary.	