STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 survey was conducted on 07/06/21 through 07/07/21. The facility was found in compliance with the requirment CFR 483.73, Emergency Preparedness. Event ID: CZH011.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted on 07/06/21 through 07/07/21. Event ID #CZH011.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		7/9/21

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

Electronically Signed | 07/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff and Medical Doctor interviews the facility failed to follow a resident's wishes for Do Not Resuscitate (DNR) status as specified in their advance directives when Resident #61 went into cardiac arrest (heart stopped) and the facility began Cardiopulmonary Resuscitation (CPR) for 1 of 1 death records reviewed. The findings included: Resident #61 admitted to the facility on 11/04/20 with diagnoses including heart failure, atrial fibrillation, heart block and coronary artery disease. Review of a physician order dated 11/04/20 read; Do Not Resuscitate (DNR). Review of admission Minimum Data Set (MDS) dated 11/06/20 indicated that Resident #61 was moderately impaired for daily decision making and required limited to extensive assistance with	F 578	F578 - Request/Refuse/Discontinue Treat CFR: 483.10c (6) (8) (g) (12) (I)-(v) On 11/8/2020 the incident was reported to risk management for review through RL6 reporting system. On 11/11/2020 staff education was done utilizing a visual algorithm outlining the DNAR Scope of Treatment Order process. Information Technology was made aware of the issue related to the code status dropping off with the LOA ED visit. A manual process was implemented immediately for reviewing all patients on LOA and verifying code status upon return. A root cause analysis on the incident was also completed in December of 2020. Outcomes of the root cause analysis identified the need for reinforced staff education which was completed, and an issue with the code status dropping off of the electronic medical record with an ED visit which had been referred to IT. IT and the EPIC build team proceeded to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 578	Continued From page 2 activities of daily living. Review of a nurses note dated 11/07/20 read in part, Nurse Aide (NA) "in room to check resident and he was noted to have agonal" (abnormal breathing) "breathing with oxygen in place, rapid response was called at 2236 (10:36 PM). Resident stopped breathing and was unresponsive at 2238 (10:38 PM) Code Blue was called and CPR started. Shock given at 2243 (10:43 PM) for" VFib (heart quiver). Medical Doctor (MD) in room to assess and called code at 2245 (10:45 PM) and pronounced resident dead at that time. Family notified. The note was signed by Nurse #1. Nurse #1 was interviewed on 07/07/21 at 2:16 PM. Nurse #1 stated that she generally worked the night shift from 7:00 PM to 7:00 AM on the unit. She stated she "kind of remembered" the event on 11/06/21 but nothing specific. She stated she was sure she was aware of Resident #61's code status but could recall anything specific about the situation as to why Resident #61 was coded. Nurse #1 stated that generally they obtained code status during report and then it was kept on a resident's bracelet and in the computer. She explained if she found a resident not breathing, the first thing she would do was to determine the resident code status by looking on their bracelet and then verify that by looking in the computer. Again Nurse #1 stated that she could not recall that far back and could not speak to any details about the incident. Review of note from the Medical Doctor (MD) dated 11/06/20 read in part, I was working in the emergency department (ED) "when code blue was called at 2238" (10:38 PM). I and a nurse	F 578	research, test, and complete a final fix to the electronic medical record to prevent the code status dropping off. This final fix was implemented on 7/1/2021. Staff education for the electronic medical record process was initiated on 7/1/2021 and completed on 7/9/21. Performance monitoring will be completed on all patients placed on LOA status for visits to the ED. 100% of charts will be reviewed from 7/2 2021 ongoing through the next 6 months. Random monitoring will occur thereafter the 6-monoth period on an ongoing basis. The Code Status monitoring will be incorporated into the QAPI monitoring plan for resident's rights and safety. Data will be reported at least quarterly to the QAPI team. The process for resident Code Status and Scope of Treatment Order will be incorporated into all new SNF staff orientation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 578	Continued From page 3	F 578		

responded to the code. When we arrived Cardiopulmonary Resuscitation (CPR) was in process. Patient was being bagged by Respiratory Therapist (RT) without difficulty. "Shortly after I arrived rhythm checked and showed VFib. Patient was shocked unsynchronized at 200 joules and CPR was resumed. Nursing then notified me that patients chart indicated he was a DNR. Patient then noted to have a DNR bracelet on. At that time another pulse check was performed, and patient was noted be pulseless. In accordance with the patient's wishes resuscitative efforts were stopped at 2245" (10:45 PM). I notified the hospitalist of the events and Nursing contacted the family. Signed by the MD.

The MD was interviewed on 07/07/21 at 3:35 PM. The MD explained that he was working in the ED on 11/06/20 when a code blue was called and per their protocol, he and a Nurse from the ER responded. The MD stated that when he entered the room there were various staff members actively trying to resuscitate Resident #61. The MD stated he did not know any of the staff in the room as he was assigned to the ER. The MD stated that shortly after he arrived the staff did a rhythm check which showed Vfib and we provided a shock to Resident #61 and continued with CPR. During this scene one of the nurses stated that she saw something in his chart that stated he was a DNR and then another staff member stated oh yes, I see his DNR bracelet. The MD stated when he saw that he did a rhythm check and Resident #61 was pulseless, so the resuscitative efforts were stopped, and Resident #61 was pronounced dead. The MD stated if he had known that Resident #61 was a DNR he would not have shocked him, and the CPR would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 578	Continued From page 4	F 578		

have been stopped. He continued to say that he was informed that when Resident #61 went to the ER earlier that day the computer software had erased his code status. The MD stated that the issue had since been corrected with their software company and that when a resident was transferred from one unit to another the orders stayed the same unless changed by the provider including code status.

The RT was interviewed on 07/07/21 at 3:20 PM. The RT confirmed she responded to Resident #61's code on 11/06/20. She stated when she arrived at the room, it was full of other staff members and they had the code cart and were actively coding or performing CPR on Resident #61. The RT stated that at the time she assumed the staff had already verified his code status but at some point, during this code the nursing staff had discussion about his code status and someone stated he was a DNR. She added that the MD arrived around the same time she did and when he heard that the resident was a DNR the code was called, and Resident #61 was pronounced deceased by the MD. The RT stated she did not recall if Resident #61 had a DNR bracelet on or not, she explained she was responsible for airway and did not generally pull a chart or look at bracelet when she entered a room and the resident was already being actively coded with CPR in progress.

The Charge Nurse (CN) was interviewed on 07/07/21 at 3:56 PM. The CN explained that when Resident #61 went to the ER on 11/06/21 the staff had transferred him on a leave of absence and when they did that the computer software erased the code status from Resident #61's chart. When the staff reentered Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 578	Continued From page 5	F 578		

#61 from the leave of absence, they should have had the provider reenter the code status, but they did not know that it had been erased and had no code status. When Resident #61 went into cardiac arrest the staff coded him even though he had a DNR bracelet on and they should not have. The CN stated that they worked with the IT department to fix the software issue and during that time talked to the staff individually and gave them a copy of our DNR policy and posted it in the nurses station. She added that the Nurse Manager placed the information on the hot topic that was electronically sent out to all staff and we continued to discuss code status during each shift report so that everyone was aware of the code status. The CN stated that the software had been corrected and no longer erased any orders when a resident was placed on leave of absence.

The Nurse Manager (NM) was interviewed on 07/07/21 at 11:00 AM. The NM stated that Resident #61 had cardiac arrest and was coded by the staff and he should not have been because he had a DNR in place. The NM stated that what occurred was earlier in the day on 11/06/20 Resident #61 had a fall in his room and had hit his head and was transferred to the Emergency Room (ER) for a scan of his head. When Resident #61 left the facility to go to the ER the staff placed Resident #61 on a leave of absence. Resident #61 returned to the facility a short time later and the staff took him off the leave of absence but unknown to them his code status had been wiped clean from the electronic medical record. The NM explained after the event we began to look at why that occurred and discovered it was something in our software design that occurred when a resident was placed on a leave of absence. When a resident was on a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 578	Continued From page 6 leave of absence the software was prompting for the code status to be reentered however the staff did not know that it needed to be reentered. The NM stated that they worked with Information Technology (IT) to correct the issue and a new software version was released on July 01, 2021 that corrected the issue. So now when a resident was placed on a leave of absence (sent to the ER) and returned everything stayed the same with code status and nothing was wiped out.	F 578		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655		8/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 655	Continued From page 7 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews the facility failed to develop a baseline care plan for a resident on fluid restrictions (Resident #55) and for a resident that was receiving an anticoagulant (Resident #156) for 2 of 6 residents reviewed for care plans. The findings included: 1. Resident #55 was admitted to the facility on 07/01/21 with diagnoses that included hyponatremia (low sodium level). Review of a physician order dated 07/01/21 read; fluid restrictions 1500 milliliters (ml) per day due to hyponatremia. Review of a care plan titled Fluid volume created on 07/02/21 read; fluid volume will improve, and fluid intake will improve.	F 655	F 6555 - Baseline Care Plan 483.21 Comprehensive Person-Centered Care Planning Interventions to address fluid restrictions and anticoagulant therapy were added to the impacted residents existing plans of care on 7/7/21. Immediate verbal in servicing was done with the SNF staff on duty 7/7-7/8/2021. A review of current residents was performed on 7/8/21 to confirm a comprehensive plan of care was implemented with all required elements of the individual patient needs. A review of available plans of care was conducted on 7/8/21. IT was contacted on 7/9/21 to initiate a care plan build for Fluid Restrictions and Anticoagulant therapy for the electronic record. Research and best practice for care plan interventions for the identified problems	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 655	Continued From page 8 No Minimum Data Set (MDS) information was available. An observation and interview were conducted with Resident #55 on 07/06/21 at 10:13 AM. Resident #55 was sitting up in her chair and had her feet elevated. There was a sign above her bed that read; fluid restriction 6:00 AM to 6:00 PM= 1000 ml and from 6:00 PM to 6:00 AM=500 ml. Resident #55 stated that she had a chronically low sodium level and stated if she drank too much water it would bring her sodium level down even lower. Resident #55 stated that at home she drank electrolyte replacement which helped bring her sodium up a little bit. She confirmed that she remained on a fluid restriction to help keep her sodium level up. An interview with Nurse #2 on 07/07/21 at 2:42 PM revealed she was familiar with Resident #55 and was aware Resident #55 was on fluid restrictions. She was unaware if the facility had a specific care plan for fluid restrictions but stated the Charge Nurse (CN) would know. She added that Resident #55 had a fluid volume care plan in place but did not know if fluid restrictions could be added or not. The Charge Nurse (CN) was interviewed on 07/07/21 at 10:33 AM. The CN stated that the admission nurse was responsible for entering care plan when a resident admitted to the unit. She added that when she completed the comprehensive MDS she would ensure that all care plans that were needed were in place and update them as needed. The CN was not aware if there was a care plan for fluid restrictions or not. She said they have 1000 care plans to choose	F 655	was completed on 7/23/21. Hard copy plans of care for fluid restrictions and anticoagulant therapy were completed and initiated on 7/28/21 with content sent to IT for incorporation into the electronic care plan system. Effective July 9 2021 Performance monitoring of appropriate comprehensive plans of care per resident was initiated and will be ongoing through the next 6 months. A staff education plan of initiation of comprehensive plans of care individualized to patient needs including for fluid restrictions and anticoagulant therapy will be completed by 8/3/2021. All new resident care plans are placed on 100% monitoring for the next 6 months to ensure timely completion and individualization of resident need including the additions of fluid restrictions and anticoagulant therapy as applicable. Random monitoring will occur thereafter the 6-monoth period on an ongoing basis. The care plan process will continue to be incorporated into the QAPI monitoring plan with data presented at least quarterly to the QAPI team. The care plan process will continue to be incorporated into all new SNF staff orientation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 655	Continued From page 9	F 655		

from but was not sure if they included fluid restrictions or not, but she would look into it.

2. Resident #156 was admitted to the facility on 07/03/21 with diagnoses that included history of stroke, atrial fibrillation, and hypertension.

Due to Resident #156's recent admission, a Minimum Data Set Assessment review was unable to be completed.

A review of Resident #156's electronic physician orders revealed an order dated 06/29/21 for warfarin, an anticoagulant, 2.5 milligram (mg) tablet once daily.

A review of Resident #156's care plan dated 07/03/21 revealed no care plan for the use of anticoagulants.

An interview with Nurse #2 on 07/07/21 at 2:42 PM revealed she was familiar with Resident #156 and was aware Resident #156 was receiving anticoagulation medications. She was unaware if the facility had a specific anticoagulant medication care plan and reported the Charge Nurse would know.

An interview with the Charge Nurse on 07/07/21 at 3:57PM revealed nursing was responsible for entering care plans into the resident's electronic medical records and she verified them when she completed the comprehensive assessments. She reported staff monitor all the residents for potential side effects of prescribed medications, but the facility did not have a specific anticoagulant medication care plan built into their electronic medical record system. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345386	A. BUILDING _____ B. WING _____	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILKES REGIONAL MEDICAL CTR SN	1370 WEST D STREET NORTH WILKESBORO, NC 28659

(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 655	Continued From page 10 most, if not all of the residents in the facility are on anticoagulant medications and was certain the nurses monitored for side effects. She stated she thought that they could create an anticoagulation care plan and would look into it.	F 655		