STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 04/26/21 through 04/29/21 The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1MKD11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/26/21 through 04/29/21. Eight of the seventeen complaint allegations were substantiated resulting in deficiencies. Event ID# 1MKD11. The 2567 was to be submitted to the facility on 5/13/21 and was delayed until 5/14/21 due to management review of the citations.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		5/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/24/2021

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

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F 550 Continued From page 1
must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and resident and staff interview, the facility failed to treat a resident with dignity who called out for staff assistance to provide a blanket (Resident #76) and made her feel "disregarded", the facility also failed to treat a resident in a dignified manner when she turned on her call light to request assistance with incontinence care and described she was tearful, very upset and embarrassed at the situation (Resident #136) for 2 of 5 residents reviewed for dignity.

she was tearful and very upset at the situation because it was "hard enough for me to be here and have to ask people for help" and then the staff makes you feel like that when you do ask for

F 550

Please accept this plan of correction as Surry Community Health & Rehabilitation Centers credible allegation of compliance for the alleged deficiencies cited.
Submission and implementation of this plan of correction is not an admission a deficiency exists or one was cited correctly.
The Plan of Correction is submitted to meet requirements established by Federal and State law, which requires an acceptable plan of correction a condition of continued certification.

F 550 Residents Rights/Exercise of Rights

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 550 Continued From page 2

help. Resident #136 also added "it is so embarrassing when I wet through my brief and the bed it makes me feel like a child."

Findings included:

1. Resident #76 was admitted to the facility on 03/19/21 with diagnoses that included cerebral infarction with hemiplegia to the right side (stroke with right side impairment), metastatic cancer (cancer spread from its origin), and history of falling.

Resident #76's Admission Minimum Data Set (MDS) dated 3/26/21 indicated she was cognitively intact without symptoms of delirium and had experienced no episodes of behaviors or rejections of care.

An interview on 04/26/21 at 12:24 PM with Resident #76 revealed she did not feel like staff treated her with dignity and respect and stated they sometimes tell her to shut up.

An observation on 04/26/21 at 4:00 PM revealed Resident #76 sitting in bed with a sheet partially draped over her lower extremities. Resident #76 was heard hollering "Grandma" to obtain staff assistance from Nurse Aide (NA) #2. Her call light was not on at the time and the call light was observed to be laying on the overbed table which was positioned approximately 2 feet away from Resident #76's bed at the time of her hollering out. NA #2 ambulated past Resident #76's room and hollered back at Resident #76, "What is it?" then entered another resident's room across the hall. When NA #2 exited the other resident's room and ambulated in front of Resident #76's room, Resident #76 again hollered "Grandma". NA #2

F 550

Resident # 76 was provided a blanket by the Director of Nursing. Her call light was placed within reach.
Resident #136 upon notification DON met with resident who agreed to meet with TNA #1 who apologized and stated understanding of how resident was made to feel.

All residents have the potential to be affected by this deficient practice. Alert and oriented residents on 200 hall and 400 halls were interviewed and no other issues were noted.
On 4-27-2021 a surveyor met with the DON and Administrator and voiced that NA #2 had replied to resident in a gruff tone. DON immediately went to resident #76 room and interviewed her along with NA #2. Social Services Director was notified and also interviewed resident #76 along with several other residents on the hall. No residents voiced concerns with NA #2.
On 4-26-2021 resident #136 nurse reported to the DON the resident # 136 had a concern. DON Meet with this resident and began the concern for process. No other residents voiced concerns with TNA #1.

One to one re-education was provided on customer service/treating residents with dignity to TNA#1 and NA#2. Customer service training was initiated for all staff on 5-3-2021 and will be completed by 5/26/2021. This education will be provided to new hires during orientation.

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F 550	Continued From page 3 entered Resident #76's room, approached the bedside, and yanked the curtain partially around Resident #76. NA #2 then said to Resident #76, "What do you want now?" Resident #76 told NA #2 she was "freezing" and requested a blanket. NA #2 then told Resident #76 she did not need another blanket she had one and proceeded to yank the sheet to cover Resident #76 before she exited the room. Resident #76's bed was not observed to contain a blanket, there was only a sheet on the bed during the observation. An interview on 04/26/21 at 4:15 PM with NA #2 revealed she had entered Resident #76's room after Resident #76 had identified her and hollered out for her directly. NA #2 acknowledged when she entered the room, Resident #76 requested a blanket, but she did not provide Resident #76 a blanket because she felt Resident #76 did not need an additional blanket because she already had cover on her bed and only needed to be covered back up with it. NA #2 did not feel it was undignified to speak to Resident #76 in the manner observed nor to not fulfill the service requested of the resident. A follow-up interview on 04/27/21 at 11:24 AM with Resident #76 revealed she recalled the incident with NA #2 on 04/26/21. Resident #76 reported even after being covered up by NA #2 she remained cold and wanted another blanket. She stated the way NA #2 failed to provide her a blanket and how she was "disregarded" made her "feel like shxx." She stated she eventually received the blanket over an hour after she requested one. An interview on 04/29/21 at 12:00 PM with the Director of Nursing revealed she had been made	F 550	Director of Nursing /Administrator / Social Services Director will conduct 5 random interviews weekly x 12 weeks. Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.	

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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F 550	Continued From page 4	F 550		

aware of the interactions between Resident #76 and NA #2 on 04/26/21. The DON stated she believed NA #2 naturally spoke louder and rough in her tone. NA #2 had received education on customer service and should have provided Resident #76 with a blanket when she told NA #2 she was cold instead of covering her with only the sheet on her bed and left Resident #76's room.

An interview on 04/26/21 at 4:30 PM with the Administrator revealed she did not feel Resident #76 should have been addressed from the hallway and felt NA #2 should have provided the services requested by Resident #76.

2. Resident #136 was admitted to the facility on 03/11/21 with diagnoses that included chronic obstructive pulmonary disease, emphysema, diabetes, and others.

Review of the comprehensive Minimum Data Set (MDS) dated 04/09/21 indicated that Resident #136 was cognitively intact for daily decision making and required extensive assistance with toileting. The MDS further indicated that Resident #136 had no behaviors or rejection of care during the assessment reference period.

An interview was conducted with Resident #136 on 04/27/21 at 4:19 PM. Resident #136 stated that on 04/26/21 she had rung her call light 3 times requesting her medication and the nurse was really busy but at approximately 9:00 PM she rang her call light for the 4th time because she needed to be changed. Resident #136 stated, "I was soaked and if I would have waited any longer the bed would have been soaked too." Resident #136 stated that Training Nursing Assistant (TNA)

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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F 550	Continued From page 5 #1 was standing outside of her door by herself just visible to her and when she turned on her call light, she heard TNA #1 say, "what the hell does she want now." Resident #136 stated she had her mind and TNA #1 stated that she was just playing, and Resident #136 replied no you were not. She added that TNA #1 turned the light off and stated she would change her, and Resident #136 told TNA #1 that she was not going to touch her and to get out of her room. TNA #1 left the room without apologizing and Nurse #1 came to the room to provide the care. Resident #136 stated that TNA #1 returned to her later and stated she was going to change her again and again was told to leave her room and not return. Resident #136 stated that she was tearful and very upset at the situation because it was "hard enough for me to be here and have to ask people for help" and then the staff makes you feel like that when you do ask for help. Resident #136 also added "it is so embarrassing when I wet through my brief and the bed it makes me feel like a child." An interview with the Assistant Director of Nursing (ADON) was conducted on 04/27/21 at 4:44 PM. The ADON stated she was asked to go and see Resident #136 and she told me that she overheard TNA #1 in the hallway make comments in regard to her call light. The ADON stated that it really hurt Resident #136's feelings and she assured Resident #136 that TNA #1 would not come back in her room. The ADON stated she apologized for TNA #1's behavior and again assured her that she would not come back in her room. She added she reported the incident to the Director of Nursing (DON) and the Administrator who would follow up.	F 550		

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F 550	Continued From page 6 An interview was conducted with TNA #1 on 04/28/21 at 2:43 PM. TNA #1 stated that on the evening of 04/26/21 she working the unit by herself and it was really busy and approximately 20 call lights had been on and then Resident #136 turned on her call light and she said something to the effect "good lord another call light." TNA #1 stated that Nurse #1 was standing close by and heard what was said but really did not pay much attention because she was busy. TNA #1 stated that her comment was not directed towards anyone and that Resident #136 took it personal and told me that there was no excuse and to leave her room. TNA #1 stated she could not recall word for word what she said but it was just a bad night and her comment was not directed towards anyone including Resident #136, she added she knew that residents should not over hear the things staff said but again she did not mean to insult her. TNA #1 stated, "I guess not running my mouth would have been a good idea" but TNA #1 indicated she was complaining to herself. She further stated, "I was not worried about it because most resident would not say anything about it." TNA #1 stated that Resident #136 was not crying but she did have a "tone" to her voice. She further stated "some older people take things the wrong way" and she reported to Nurse #1 that Resident #136 was mad and would not let me change her, so Nurse #1 proceeded to care for Resident #136 for the rest of the shift. An interview was conducted with Nurse #1 on 04/28/21 at 5:06 PM. Nurse #1 stated that on the evening of 04/26/21 Resident #136 had rung her call light 2-3 times in a 10 minute window requesting medication and I told her to just give me a minute and I would get to her as soon as possible and Resident #136 was fine with that	F 550		

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F 550	Continued From page 7 and stated she understood. Nurse #1 stated she took her medication cart down the hallway and parked it right outside of Resident #136's room and was pulling her medication and she again turned her call light on and TNA #1 stated what does she want now and I stated "well go and see." Nurse #1 stated she heard Resident #136 say to TNA #1 go and get the nurse, so I walked into her room and shut the door. Resident #136 was tearful and stated she did not deserve to be treated like that and that she was not ringing for pain medication, but she needed to be changed. Nurse #1 indicated she was not aware initially that Resident #136 overheard what TNA #1 stated and that it was not an appropriate statement to say when a resident could hear it. Nurse #1 stated she cared for Resident #136 for the remainder of the shift and spoke with TNA #1 that she had to be mindful of what she said and who was around to hear it and she did apologize to Resident #136 for TNA #1's behavior. An interview was conducted with the DON and the Administrator on 04/29/21 at 2:29 PM. The DON stated that she went and spoke with Resident #136 and she was tearful and stated she did not want TNA #1 back in her room. The DON stated she apologized for TNA #1's behavior and that she had counseled TNA #1 about not saying things where residents could overhear them. The DON and Administrator both stated that they did not want their resident feeling less then dignified and TNA #1 should have not made the comment where Resident #136 or any resident could have overheard it.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		5/26/21

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 558	Continued From page 8 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interview, the facility failed to ensure a call light was in reach for a resident identified to be a high risk for falls for 1 of 4 residents reviewed for accommodation of needs (Resident #76). Findings included: Resident #76 was admitted to the facility on 03/19/21 with diagnoses that included cerebral infarction with hemiplegia to the right side (stroke with right side impairment) and history of falling. An Admission Minimum Data Set (MDS) dated 03/26/21 indicated Resident #76 was cognitively intact and required extensive assistance of 1 to 2 staff for all activities of daily living (ADL). A fall care plan dated 03/22/21 indicated an intervention of ensure call light is within reach and encourage resident to use it for assistance as needed. An activities of daily living (ADL) care plan dated 03/26/21 with intervention to include encourage Resident #76 to use her call light to call for assistance. An observation on 04/26/21 at 4:00 PM revealed Resident #76 sitting in bed with a sheet partially	F 558	F558 Reasonable Accommodations Needs/Preferences Nursing staff ensured call light was within reach of resident # 76. All residents have the potential to be affected by this deficiency. Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator and Unit Manager completed 100% audit of call bells on 5/3/2021. No additional issues were identified during the audit. The Director of Nursing and/or the Assistant Director of Nursing will re-educate staff on placing the call bed within the residents reach. This education will be provided to new hires during orientation.This education will be completed by 5/26/2021. The Director of Nursing and/or the Assistant Director of Nursing will conduct weekly audits to ensure call lights are within reach. They will audit 10 random rooms weekly X 12 weeks. The results of these audits will be presented by the Director of Nursing for 3 months at the facility QAPI meeting to evaluate effectiveness. The QAPI committee will	

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F 558	Continued From page 9	F 558		

draped over her lower extremities. Resident #76 was heard hollering for staff assistance. Her call light was not on at the time and the call light was observed to be laying on the overbed table which was positioned approximately 2 feet away from Resident #76's bed at the time of her hollering out.

An observation on 04/27/21 at 9:13 AM revealed Resident #76's call light on the floor behind her bed and out of reach of Resident #76.

An observation on 04/28/21 at 10:48 AM revealed Resident #76 hollering out through her closed door. When the surveyor entered the room, Resident #76's right arm was caught underneath the right side of her body and she was unable to move it and was hollering for assistance. Resident #76's call light was observed to be on the overbed table approximately 2 feet away and not within reach of Resident #76.

An interview on 04/26/21 at 4:00 PM with Resident #76 revealed she was cold and needed assistance with a blanket and could not get to her call light to call for assistance and therefore she was hollering for staff assistance. Resident #76 indicated staff often leave it on the table and she is unable to reach it when she needs something.

An additional interview on 04/28/21 at 10:48 AM with Resident #76 revealed she had attempted to move about in her bed which caused her to get her arm pinned under her body on the right side due to her hemiplegia and was unable to access her call light and therefore she was hollering out for staff assistance.

An interview on 04/26/21 at 4:30 PM with Nurse

Provider's plan of correction (F 558):

make changes and recommendations as indicated.

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F 558	Continued From page 10 Aide (NA #3) revealed she was not sure why Resident #76's call light was not in place. NA #3 indicated Resident #76's call light should have been within her reach in order to call for staff assistance. An interview on 04/29/21 at 3:30 PM with Nurse Aide (NA#1) and Training Nurse Aide (TNA #1) revealed they were unsure why Resident #76's call light was not within her reach and had been educated resident call lights were to be left within reach in order for the resident to call for assistance. An interview on 04/29/21 at 12:00 PM with the Director of Nursing (DON) revealed all staff had received training on call light and were knowledgeable that all call lights were to be within reach and answered promptly. She was unsure why Resident #76's call light would not have been within her reach preventing her from using it to call for staff assistance on multiple occasions between 04/26/21 and 04/29/21.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 583

Continued From page 11

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, family, and staff interviews the facility failed to protect the protected health information for 1 of 3 (Resident #43) residents whose medication was sent home with another resident (Resident #289) that contained personal health information like the resident name, room number, and physician, and failed to provide full visual privacy during a therapy treatment for 1 of 1 (Resident #288) resident reviewed for privacy.

The findings included:

1. Resident #43 was admitted to the facility on 02/28/20 with diagnoses that included heart disease, vascular dementia, anxiety, and others.

F 583

F583 Personal Privacy/Confidentiality of Records

Resident #43 has been discharged from this facility.

All residents have the potential to be affected by this deficient practice. Review of concerns revealed no privacy concerns.

The Director of Nursing and/or Assistant Director of Nursing and/or Designee will reeducate nursing staff and the SW/Discharge Residents on the Right to secure and confidential personal and medical records. This education will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 583	Continued From page 12 Review of a quarterly Minimum Data Set (MDS) dated 04/14/21 indicated that Resident #43 was severely cognitively impaired for daily decision making and had no behaviors during the assessment reference period. Review of a physician order dated 10/02/20 read, Celexa (antidepressant medication) 15 milligrams (mg) by mouth every day for depression/anxiety. An interview was conducted with a family member of Resident #289 on 04/28/21 at 1:53 PM. The family member stated Resident #289 discharged home from the facility on 02/05/21. She stated she had come to the facility to pick up his belongings and when she got home, she discovered the facility had inadvertently sent a card of medication that belonged to Resident #43. The family member stated that the card of medication was Celexa 20 mg and there were 4 pills left in the card of medication. She added that she made sure Resident #289 did not take any of the medication that did not belong to him, but she was worried that the facility may have given the wrong medication if they sent it home with her family member. The family member stated she had placed the medication in a safe place until she could return it to the facility. Review of a picture received via text message was made on 04/28/21 at 2:11 PM from Resident #289's family member. The picture was of Resident #43's medication card. The label contained Resident #43's name, room number, physician, and dosing instructions for the Celexa. The card of Celexa contained 4 pills. An interview was conducted with Nurse #4 on	F 583	provided to new hires during orientation.This education will be completed by 5/26/2021. At least two discharges weekly for 12 weeks will be reviewed by the Director of Nursing/Assistant Director of Nursing prior to discharge to ensure the residents right to personal privacy and confidentiality is maintained. The Director of Nursing will report these finding for 3 months at the facility QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 583	Continued From page 13	F 583		

04/29/21 at 4:01 PM. Nurse #4 confirmed that she had discharged Resident #289 on 02/05/21. She stated that his family came to the facility to pick up his belongings and sign the paperwork. Nurse #4 stated she did not recall whether or not she sent his medication home with him or not. She stated some residents do discharge with their medications so she could have but could not recall with certainty. When asked if she sent Resident #43's medication home with Resident #289 she stated, "maybe her card of medication was on top of my med cart and I picked it up with the paperwork." Nurse #4 stated if that is what occurred it was totally by accident.

An interview was conducted with the Administrator and Director of Nursing (DON) on 04/29/21 at 4:15 PM. The DON stated she nor the Administrator had heard of any issues with Resident #289's discharge and were not aware of Resident #43's medications being sent home with Resident #289. Both the Administrator and DON stated they expected the correct medication to be sent home with the correct resident so that personal protected health information remained confidential.

2. Resident # 288 was admitted to the facility on 04/07/21 with diagnosis that include multiple fractures to include the left femur neck, right talus, left humerus, left rib, wedge compression fracture of the first lumbar vertebra, and communication deficits.

An Admission Minimum Data Set (MDS) dated 04/14/21 indicated Resident #288 was cognitively intact and required extensive assistance of 2 staff members for bed mobility and bilateral impairment of both upper and lower extremities.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 583	Continued From page 14 An observation on 04/26/21 beginning at 3:45 PM and ending at 3:50 PM revealed Therapy Assistant #1 (PTA #1) was at Resident #288's bedside providing physical therapy training to include lower extremity exercises. Resident #288 was observed in bed wearing a hospital gown with her lower extremity skin exposed to her thigh and with the privacy curtain located at the upper portion of her bed and not drawn for privacy during the therapy session. Resident #288's roommate was in the room at the time and another member of the therapy department was at the resident's door observing. An interview on 04/26/21 at 3:50 PM with PTA #1 revealed she had been assigned to provide physical therapy with Resident #288 on 04/26/21. PTA #1 stated Resident #288 had experienced increase agitation on that day and therefore she did not think to pull the privacy curtain nor close the door for privacy before beginning the therapy session which caused exposure of Resident #288 lower extremity from the doorway. An interview on 04/29/21 at 12:00 PM with the Director of Nursing (DON) revealed she expected PTA #1 to provide privacy during care to include the privacy curtain to be placed around Resident #288's bed or closing Resident #288's door before beginning treatment. The DON stated all staff had received education on providing privacy.	F 583		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 15 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff,	F 584	F584 Safe/Clean/Comfortable/Homelike	

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F 584

Continued From page 16

resident and family interviews, the facility failed to unpack a resident's clothing stored in duffle bags (Resident #25) failed to unpack a resident's personal belongings (Resident #47) and also failed to provide a clean window sill by removing dead flowers and partially eaten food and remove a pile of dirty laundry from a resident's room (Resident #52) for 3 of 31 residents reviewed for the environment.

The findings included:

1. Resident #25 was admitted to the facility on 01/29/21.

Resident #25's annual Minimum Data Set assessment dated 02/26/21 indicated she was cognitively intact.

On 04/26/21 at 4:22 PM an interview and observation were made in Resident #25's room of 3 duffle bags laying on the floor under a straight back chair in the corner of her room. Resident #25 explained that she had clothes in the duffle bags and had nowhere to put them other than her closet which already contained her hanging clothes. The Resident stated she would like something to put her clothes in, but she had never been offered anything to store her clothes in.

An observation on 04/27/21 at 4:03 PM revealed the 3 duffle bags remained on the floor under the straight back chair.

An observation on 04/29/21 at 12:05 PM revealed the 3 duffle bags remained on the floor under the straight back chair.

F 584

Environment

Staff unpacked resident #25 clothing from a duffle bag, unpacked resident #47 personal belongings and cleaned the window sill by removing dead flowers and partially eaten food. Dirty laundry was removed from resident #52 room.

All residents have the potential to be affected. All residents rooms were assessed and any personal belongings were put away as needed/appropriate. Any laundry found to be out of place was also put in the proper place. Window seals were cleaned.

Re Education to be provided to all staff regarding Safe/Clean/Comfortable/Homelike Environment. This education will also be provided to new hires in orientation. This education will include ensuring clothing is unpacked appropriately, belongings are unpacked, laundry is not piled in the room and the window sills are free from food and dead flowers. This education will be completed by 5/26/2021.

The Administrator/DON will audit 10 random rooms weekly for 12 weeks. The results of these findings will be presented to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 17 During an interview with Housekeeper #1 at 12:05 PM on 04/29/21 she explained the housekeepers did not touch the residents' clothes or personal belongings. She stated they would move the duffle bags out to sweep and mop then replace them. An interview was conducted with the Housekeeping Supervisor (HS) on 04/29/21 at 12:21 PM. The HS explained the housekeepers did not touch the residents' clothes or personal belongings nor did they put the residents' clothes away. He continued to explain that the Administrator assigned the department managers to be Ambassadors for the residents which meant the department managers were assigned certain residents and rooms that they were supposed to monitor every day for a safe, clean and homelike environment and report the findings back to the Administrator. An interview was conducted with the Admissions Coordinator (AC) on 04/29/21 at 12:35 PM. The AC confirmed she was the Ambassador assigned to Resident #25 and her room and made Ambassador rounds almost every day. She explained that she looked at things like the appearance of the resident and the condition of the rooms such as if the lights and remote controls were working correctly. The AC continued to explain that the Ambassadors brought their findings back to the morning management meeting so that all the department managers would be made aware of the issues that were found and needed to be taken care of. The AC stated Resident #25 was very neat and organized and liked her personal belongings organized. The AC also added that she had not noticed the 3 duffle bags stored on the floor in the	F 584		

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F 584	Continued From page 18 Resident's room therefore, she had not asked Resident #25 if she wanted her belongings appropriately stored away. An interview was conducted with the Director of Nursing (DON) on 04/29/21 at 5:21 PM. The DON explained that each resident and resident room was assigned an Ambassador who was responsible for visiting that resident daily to identify issues with that resident and bring the issues to the morning management meeting. The DON stated she could see where they (facility) could do a better job at identifying ways to keep the resident's room neat, clean and orderly and added she needed to make Ambassador rounds herself to identify the issues because ultimately it was her responsibility to make sure the resident rooms were neat, clean and orderly. During an interview with the Administrator on 04/29/21 at 5:44 PM she explained that the department managers conducted daily Ambassador rounds in order to identify issues the residents may have or issues with their rooms. She continued to explain that Resident #25's duffle bags being stored on the floor should have been identified and storage bins should have been provided for the Resident to prevent her belongings from being stored on the floor. 2. Resident #47 was admitted to the facility on 01/22/21. Resident #47's quarterly Minimum Data Set assessment dated 03/08/21 indicated he was cognitively intact. On 04/26/21 at 3:13 PM an interview and observation were made of Resident #47's room of	F 584		

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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F 584	Continued From page 19 3 boxes stacked up at approximately 4 and a half feet in the corner at the foot of the bed. Various items such as clothes, papers, and hospital equipment cluttered the top of the boxes. The window sill and bedside table contained various items such as hospital equipment dishes, cups and papers cluttered on the structures. Resident #47's wheelchair had a bag of personal belongings laying in the seat that he had brought from the hospital that day, (04/26/21). Resident #47 explained that he had been hospitalized for approximately 2 weeks and returned on 04/26/21 but the boxes had been stacked up in the corner since before he went to the hospital. The Resident continued to explain that he had asked several times for some help to unpack and store his belongings but had never gotten the help he requested. On 04/27/21 at 4:08 PM an observation of Resident #47's room remained unchanged. On 04/29/21 at 11:44 AM an interview and observation were made in Resident #47's room with Nurse Aide (NA) #1 of the condition of the boxes, the window sill and bedside table which continued to have cluttered items stored on the structures. Resident #47 explained to the NA that he had asked several times for some help to unpack and store his belongings, but he had never gotten the help he requested. The NA stated it was the nurse aides' responsibility to unpack and organize the residents' personal belongings but added patient care had to come first. An interview was conducted on 04/29/21 at 11:50 AM with Nurse #2 who was the Nurse responsible for Resident #47. Nurse #2 explained it was the	F 584		

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 20 nurse aides' responsibility to keep the residents' rooms clean and clothes put away, but patient care came first. The Nurse continued to explain that the Administrator had the department managers conduct daily Ambassador rounds which would identify issues like clutter in the residents' rooms and the issues would be corrected. During an interview with the Admissions Coordinator (AC) on 04/29/21 at 12:35 PM she confirmed she was the Ambassador for Resident #47 and made rounds almost every day. She explained that she looked at things like the appearance of the resident and the condition of the rooms such as if the lights and remotes were working correctly. The AC continued to explain that the Ambassadors brought their findings back to the morning management meeting so that all the department managers would be made aware of the issues that were found and needed to be taken care of. The AC stated Resident #47's room was cluttered with boxes stacked up in the corner which could be a fall hazard for him but that he had never asked her to help him unpack his belongings nor had she offered to help him unpack his belongings. An interview was conducted with the Director of Nursing (DON) on 04/29/21 at 5:21 PM. The DON explained that each resident and resident room was assigned an Ambassador who was responsible for visiting that resident daily to identify issues with that resident and bring the issues to the morning management meeting. The DON stated she could see where they (facility) could do a better job at identifying ways to keep the resident's room neat, clean and orderly and added she needed to make Ambassador rounds	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 584	Continued From page 21	F 584		

herself to identify the issues because ultimately it was her responsibility to make sure the resident rooms were neat, clean and orderly.

During an interview with the Administrator on 04/29/21 at 5:44 PM she explained that the department managers conducted daily Ambassador rounds in order to identify issues the residents may have or issues with their rooms. The Administrator continued to explain that Resident #47 could be resistive to having his belongings unpacked and put away but added it was the facility's responsibility to offer their assistance and if he refused their assistance it would be documented.

3. Resident #52 was admitted to the facility on 12/18/19 with diagnoses that included dementia.

Resident #52's quarterly Minimum Data Set assessment dated 03/08/21 indicated her cognition was severely impaired.

On 04/26/21 at 3:01 PM an observation was made of a clothes basket that contained a pile of dirty clothes approximately 2 and a half feet tall sitting in the corner at the foot of Resident #52's bed. The window sill had two dried flower arrangements that were shedding onto the window sill.

During an observation of Resident #52's room on 04/27/21 at 4:21 PM the pile of dirty clothes in the clothes basket remained in the corner at the foot of the bed. The two dried flower arrangements were in the window sill and shedding onto the window sill and an open bag of chips were spilling out onto the window sill.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 584 Continued From page 22 F 584

An interview with Resident #52's family member was conducted on 04/28/21 at 8:50 AM. The family member explained that the Resident kept a tidy house, and everything was put away. The family member continued to explain that the family used to wash Resident #52's dirty laundry but they stopped a few months ago because it became too difficult to wash the clothes during the pandemic.

An observation was made of Resident #52's room and window sill on 04/28/21 at 9:40 AM. The condition of the room remained unchanged.

During an interview with Housekeeper #1 on 04/29/21 at 11:54 AM she explained the housekeepers swept and mopped the floor and wiped down the residents' furniture which included the window sill every day. The Housekeeper acknowledged Resident #52's clothes piled up in the corner and the dried flowers and open bag of chips on the window sill and stated the housekeepers were not supposed to touch the residents' clothing but could have moved the clothes to sweep and mop then put the clothes back. The Housekeeper offered no explanation for the dried flowers and open bag of chips in the window sill.

An interview with the Housekeeping Supervisor (HS) on 04/29/21 at 12:21 PM. The HS explained the housekeepers were not supposed to touch the residents' clothing or throw away their dried flowers because some families wanted to keep the flowers. The HS stated the open bag of chips could have belonged to the family as well. The HS explained the Administrator assigned the department managers to be Ambassadors for the residents which meant the department managers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 23	F 584		

were assigned certain residents and rooms that they were supposed to monitor every day for a safe, clean and homelike environment and report the findings back to the Administrator. The HS stated Resident #52's clothes, dried flowers and bag of chips should have been identified before now by the department manager assigned to Resident #52 and the issues should have taken care of.

An interview was conducted with the Testing Coordinator (TC) on 04/29/21 at 3:34 PM who confirmed she was the Ambassador for Resident #52. The TC explained the Ambassadors were supposed to conduct daily rounds on their assigned residents to identify issues and concerns with the residents and their rooms. The TC continued to explain that she looked for issues like the appearance of the rooms and whether the resident had any concerns she needed to bring to the Administrators attention. The TC stated she had only made rounds on Wednesday (04/28/21) thus far this week and did not notice an issue with Resident #52's clothes or the dried flowers and bag of chips on the window sill because if she had she would have reported them to the Administrator.

An interview was conducted with the Director of Nursing (DON) on 04/29/21 at 5:21 PM. The DON explained that each resident and resident room was assigned an Ambassador who was responsible for visiting that resident daily to identify issues with that resident and bring the issues to the morning management meeting. The DON stated she could see where they (facility) could do a better job at identifying ways to keep the resident's room neat, clean and orderly and added she needed to make Ambassador rounds

F 584 Continued From page 24 F 584

herself to identify the issues because ultimately it was her responsibility to make sure the resident rooms were neat, clean and orderly.

During an interview with the Administrator on 04/29/21 at 5:44 PM she explained that the department managers conducted daily Ambassador rounds in order to identify issues the residents may have or issues with their rooms. The Administrator continued to explain that Resident #52's family was responsible for her laundry, but the facility should have identified why the laundry was not getting done before it piled up like it did and the flowers and chips should not have been left in the window sill.

F 637 SS=D Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) F 637 5/26/21

§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure a significant change Minimum Data Set assessment was completed within 14 days of a resident (Resident #12) being admitted into Hospice services for 1 of 1 resident

F 637 Comprehensive Assessment After a Significant Change

Comprehensive Assessment for resident # 12 was completed to reflect a significant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 637	Continued From page 25	F 637		

reviewed for Hospice.

The finding included:

Resident #12 was admitted to the facility on 08/08/19 with diagnoses that included cerebral vascular accident (CVA).

A review of Resident #12's submitted Minimum Data Set (MDS) assessments revealed the last submitted assessment was a quarterly dated 01/23/21.

A review of Resident #12's medical record revealed an order dated 01/27/21 to evaluate and admit to Hospice if Resident #12 met the eligibility requirement for Hospice.

A review of the Hospice Certification Statement with an effective date of 02/04/21 indicated Resident #12 was certified to receive Hospice services for end of life care related to the diagnosis of cerebral vascular accident.

An interview was conducted with the Hospice Nurse (HN) #1 on 04/28/21 at 9:20 AM. The HN revealed Resident #12 was certified to receive Hospice services effective 02/04/21 for the diagnosis of cerebral vascular accident.

During an interview with the MDS Coordinator (MDSC) on 04/28/21 at 4:29 PM she explained that a significant change MDS had to be completed within 14 days of a resident being admitted for Hospice services. The MDSC confirmed there was no significant change MDS completed for Resident #12 and stated she was not sure why the significant change was missed because they (facility) discussed Hospice

change.

All hospice residents have the potential to be affected by this deficient practice. An audit was completed on all residents receiving hospice services to ensure a significant change MDS has been completed within 14 days of being admitted to hospice services. No other issues were noted.

Reeducation was provided to Resident care Management Director and the MDS Coordinator by the District RCMD on initiating a significant change MDS assessment when residents choose hospice services. This education will be completed by 5/26/2021.

RCMD/MDS coordinator will audit Hospice residents X 3 months to ensure Significant change MDS assessments are initiated timely. RCMD will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 637	Continued From page 26 services in the morning Interdisciplinary Team (IDT) meetings. An interview was conducted with the Administrator on 04/28/21 at 4:35 PM. The Administrator explained a significant change MDS after the resident was admitted for Hospice services should have been completed.	F 637		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

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F 656	Continued From page 27 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a comprehensive care plan in the area of Hospice for 1 of 4 (Resident #12) residents reviewed for Hospice services. The finding included: Resident #12 was admitted to the facility on 08/08/19 with diagnoses that included cerebral vascular accident (CVA). A review of Resident #12's medical record indicated the Resident was admitted to Hospice services on 02/04/21 for the diagnosis of cerebral vascular accident. The medical record also revealed there was no significant change Minimum Data Set (MDS) assessment related to Hospice services. An interview was conducted on 04/28/21 at 9:20 AM with the Hospice Nurse (HN). The HN confirmed that Resident #12 was eligible for Hospice services effective 02/04/21.	F 656	F656 Failure to Develop a Comprehensive Care Plan Comprehensive care plan for resident # 12 was completed to reflect hospice services provided. All hospice residents have the potential to be affected by this deficient practice. An audit was completed on all residents receiving hospice services to ensure a comprehensive care plan was present. No other issues were noted. Reeducation was provided to Resident care Management Director and the MDS Coordinator by the District RCMD on Developing a comprehensive care plan when residents choose hospice services. This education will be completed by 5/26/2021. RCMD will audit Hospice residents X 3 months to ensure Comprehensive Care	

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F 656	Continued From page 28 Resident #12's active care plan revealed there was no individualized care plan developed for Hospice services. During an interview with the Minimum Data Set Coordinator (MDSC) on 04/28/21 at 4:29 PM she confirmed there was no individualized care plan developed for Resident #12 related to the fact that the Resident began Hospice services on 02/04/21. The MDSC explained that they (facility) discussed the Hospice residents in the morning Interdisciplinary Team (IDT) meetings and she was not sure why she missed Resident #12's Hospice services. The MDSC stated she formulated the Hospice individualized care plan on 04/27/21. An interview was conducted on 04/28/21 at 4:35 PM with the Administrator who confirmed that Resident #12 began Hospice services on 02/04/21 and there was no Hospice individualized care plan formulated for Resident #12 related to the Hospice services. The Administrator was unable to explain why the individualized care plan was not developed but stated from now on they (facility) would discuss Hospice residents every morning in the IDT meetings to ensure the individualized care plans were completed.	F 656	Plans are initiated timely. RCMD will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.	
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 observation, record review, staff and	F 677	F677 ADL Care Provided for Dependent	5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 29

resident interviews, the facility failed to provide a dependent resident with nail care (Resident #62) and failed to provide showers, shampoo hair, and assist with shaves (Resident #59) for 2 of 8 residents reviewed for activities of daily living.

Findings included:

1. Resident #62 was admitted to the facility on 02/23/21 with diagnoses that included left femur fracture and diabetes.

An Admission Minimum Data Set (MDS) dated 03/21/21 revealed Resident #62 to be cognitively intact, no refusals of care, and require extensive assistance of 1 to 2 staff members for personal hygiene and bathing.

Resident #62 was not care planned for behaviors nor refusals of care.

Resident #62's selfcare deficit care plan indicated he required extensive assistance with personal hygiene and bathing.

An observation and interview on 04/27/21 at 9:35 AM revealed Resident #62's fingernails were sharp, jagged, and contained a dark brownish black substance underneath them. Resident #62 explained staff do not trim his fingernails, so he bites his fingernails when they get to long.

An observation and interview on 04/28/21 at 2:30 PM revealed Resident #62 lying in bed. His fingernails continued to have a dark substance visible under them. Resident #62 stated he was unsure why staff had not cut his fingernail. He indicated he had not refused nursing staff to provide nail care.

F 677

Residents

Resident #62 was offered nail care by hall staff and refused, but did allow the nurse to clean and trim his nails.
Resident #59 had a shower with hair washed and facial hair removed.

All residents have the potential to be affected by this deficient practice. A 100% audit was performed on 5/3/2021 for nail care, facial hair, and hair care. Any issues identified were corrected.

Reeducation was provided to nursing staff on nail care, facial care, and hair care by the Assistant Director of Nursing and the Staff Development Coordinator. This education will be provided to all new hires during orientation. This education will be completed by 5/26/2021.

The Assistant Director of Nursing/DON will audit 5 residents weekly for 12 weeks to insure nail care, shaving and hair care is provided. Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 30	F 677		

F 677

Continued From page 30

An interview on 04/28/21 at 2:40 PM with Nurse #6 revealed he was familiar with Resident #62 and verified he was responsible for his nail care due to his diagnosis of diabetes; however, he had not provided nail care to Resident #62.

An interview on 04/29/21 at 12:00 PM with the Director of Nursing (DON) revealed she expected nursing staff to provide all residents nail care with routine bathing and elaborated to state nail care for diabetic residents would be completed by the nurse.

2. Resident #59 was admitted to the facility on 08/23/19 with diagnoses that included Parkinson Disease, anxiety and depression.

Resident #59's significant change Minimum Data Set (MDS) assessment dated 03/13/21 revealed her cognition was moderately intact, she had no rejection of care, and she required extensive assistance with bathing.

Resident #59's care plan dated 03/15/21 revealed she had a self-care performance deficit related to Parkinson Disease which required supervision to extensive assistance with her activities of daily living. Resident #59 often refused to allow staff assistance with shaving facial hair. The established goal for Resident #59 was to improve her current level of function in bed mobility and would be reached through interventions such as: Resident #59 often preferred bed baths and frequently refused to allow her hair to be washed, frequently offer assistance with washing hair and encourage active participation in tasks and praise efforts in self-care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 31 A review of Resident #59's medial record from 04/22/21 through 04/28/21 revealed no refusal of care had been documented. The medical record also revealed Nurse Aide #4 initialed that Resident #59's baths were given on 04/22/21 at 9:47 PM and 11:16 PM as well as 04/26/21 at 9:52 PM and 11:56 PM. On 04/26/21 at 3:52 PM an interview and observation were made of Resident #52 who had oily straight hair and chin hairs that appeared to be approximately one quarter inch long. The Resident explained that she had not had a shower or had her hair washed in 6 weeks nor had she had her chin hair shaved which she stated she did not like. The Resident continued to explain that her showers were scheduled for Monday and Thursday evening, but she had not been taken to the shower room for her showers. An observation of Resident #59 on 04/27/21 at 4:16 PM revealed her oily hair and chin hairs remained unchanged. An observation and interview with Resident #59 on 04/28/21 at 10:21 AM revealed, the Resident's oily hair and chin hairs remained unchanged. Resident #59 stated she was not offered her shower on Monday evening and (while pointing at her hair) stated "as you can see my hair is still oily and dirty". An interview was conducted with Nurse Aide (NA) #2 on 04/28/21 at 11:18 AM who explained Resident #59 was alert and voiced her wants and needs. The NA continued to explain that the Resident sometime refused to get out of bed in the morning but Resident #59 did not refuse care. The NA stated shaves were routinely done during	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 32	F 677		

Continued From page 32

the residents' showers and that Resident #59 would let you know when she wanted to be shaved.

An observation and interview with Resident #59 on 04/28/21 at 4:55 PM revealed the Resident was lying in bed with no facial hair present. The Resident stated, "they shaved me about 45 minutes after you talked with me this morning, thank you".

On 04/28/21 at 8:33 PM a telephone interview was conducted with Nurse Aide #4 who confirmed she was scheduled for Resident #59's hall on Thursday 04/22/21 and Monday 04/26/21 from 7:00 PM to 5:00 AM. The NA explained that Resident #59's shower days were scheduled for Monday and Thursday evenings, but she normally gave her bed baths because the Resident was usually in the bed when she came on duty. The NA continued to explain that Resident #59 did not refuse care and admitted she did not shampoo the Resident's hair or shave her chin during the bed baths but added she would shave her chin that evening.

An interview was conducted on 04/29/21 at 9:30 AM with Nurse #2 who was Resident #59's full time Nurse on first shift. The Nurse explained the Resident was alert and could voice her needs. The Nurse stated Resident #59 could refuse care and when the residents refused care the aides were supposed to let the nurses know so they could document the refusal.

During an interview with Nurse Aide #1 on 04/29/21 at 10:09 AM she explained that Resident #59 was scheduled for showers on Monday and Thursday evenings. The aide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 33 continued to explain that the Resident should be taken to the shower room and her hair shampooed as well as her chin should be shaved to remove the chin hairs. The NA stated Resident #59 did not refuse care. An interview was conducted with the Infection Control Nurse (ICN) on 04/29/21 at 10:49 AM. The ICN explained Resident #59 would refuse care because she conducted an audit about 2 weeks ago and Resident #59 refused to allow the ICN to shave her facial hair. During an interview with the Director of Nursing (DON) on 04/29/21 at 5:38 PM she stated Resident #59 had a history of refusing care but regardless her hair should have been washed and her facial hair should have been shaved. The DON stated if Resident #59 refused her showers and shaves, it should have been documented.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to provide supervision to prevent a cognitively impaired resident (Resident #40) from wandering into 3 of 3 residents (Resident #4, Resident 34, Resident	F 689	F689 Free of Accident Hazards/Supervision/Devices Resident #40 was provided one to one care, a discharge plan had been made for 5/9/2021, however resident was	5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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

#132) rooms and going through their belongings, touching them, and sitting on their bed reviewed for privacy.

The findings included:

Resident #40 was admitted to the facility on 02/17/21 with diagnoses that included Alzheimer's disease with late onset, dementia, mood affective disorder, and others.

Review of a comprehensive Minimum Data Set (MDS) dated 02/24/21 indicated that Resident #40 was moderately impaired for daily decision making and required limited assistance with activities of daily living. The MDS further indicated that Resident #40 wandered 1 to 3 days during the assessment reference period that significantly intruded on the privacy of others.

Review of a care plan updated 03/04/21 read, Resident #40 was an elopement risk/wanderer related to wandering and attempted to cut off watch alert. The goal read, Resident #40's safety will be maintained through the review date. The interventions included: check placement of function of safety alert every shift, distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, books, and walking with resident. One to one as indicated, room change on 04/23/21, and wander alert as indicated.

An observation of Resident #40 was made on 04/26/21 at 11:38 AM. Resident #40 had been up ambulating independently on the unit wandering in and out of rooms that were near to her room. She keeps asking someone to make her a cup of chicken noodle soup and then continued to

F 689

discharged on 4/30/2021.

All residents have the potential to be affected by this deficient practice. On 5/3/2021 concerns for the last 30 days were audited to insure any/all issues were addressed.

Reeducation will be provided to all staff to ensure residents who wander are monitored to prevent behaviors that affect others. This education will be provided to all new hires during orientation. This education will be completed by 5/26/2021.

The Director of Nursing and/or Nursing Administration will monitor the behavior documentation and concern log for wandering behaviors in morning clinical meeting 5 times a week x 12 weeks. Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	**542 ALLRED MILL ROAD MOUNT AIRY, NC 27030**

(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 wander on the unit and in and out of other resident rooms. An observation of Resident #40 was made on 04/27/21 at 4:11 PM. Resident #40 was up ambulating on the unit and was in and out of other resident's room. The staff would attempt to redirect Resident #40 back to her room where she would stay for a minute or two then would begin wandering again. 1a. Resident #4 was readmitted to the facility on 12/31/20 with diagnoses that include chronic respiratory failure, chronic obstructive pulmonary disease, end stage renal disease and others. Review of the quarterly Minimum Data Set (MDS) dated 04/04/21 revealed that Resident #4 was cognitively intact and required extensive assistance with activities of daily living. The MDS further revealed that Resident #4 had no behaviors or rejection of care during the assessment reference period. An interview was conducted with Resident #4 on 04/26/21 at 4:31 PM. Resident #4 stated that her only complaint of the facility was that Resident #40 "wanders into my room and the other night I woke up and she was going through my pocketbook." Resident #4 also stated, "I don't have a lot but what I have I don't want her going through." She added that Resident #40 wanders all over the unit and does not wear a mask and then comes in my room and I am worried about Resident #40 getting me sick. Resident #4 stated that she would generally turn the call light on and have the staff and come and get Resident #40 from her room, but she still did not want her in her room and definitely did not want her going	F 689		

F 689 Continued From page 36 F 689

through her personal belongings.

1b. Resident #34 was readmitted to the facility on 02/04/20 with diagnoses that included diabetes, hypertension, anemia, and others.

Review of a quarterly Minimum Data Set (MDS) dated 02/13/21 revealed that Resident #34 was cognitively intact and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #34 had no behaviors or rejection of care during the assessment reference period.

An interview was conducted with Resident #34 on 04/26/21 at 11:13 AM. Resident #34 stated, Resident #40 "came in her room last night and was patting her face and legs. She got in my closet and I don't like it." Resident #34 stated she understood that they were going to take Resident #40 to another facility sometime, but she did not like it now and I have told the nurses. She added, "she rubs my face and pats my hair and I also don't like her sitting on my bed." Resident #34 indicated that Resident #40 came in her room at least 2 times a day and night. One-night Resident #40 came in my room with no pants on just her brief and I told her to go and put some pants on, but I was lying in the bed helpless and could not do anything. The staff will come and help get her out if they know she is in there and sometimes she will just turn around and leave. Resident #34 stated that Resident #40 had never hurt her or touched her inappropriately.

1c. Resident #132 was admitted to the facility on 04/08/21 with diagnoses that included encephalopathy, anxiety, dysphagia, and others.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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		

Review of the comprehensive Minimum Data Set (MDS) dated 04/15/21 revealed that Resident #132 was cognitively intact for daily decision making and required limited to extensive assistance with activities of daily living. The MDS further revealed that Resident #132 had verbal behaviors 1 to 3 days during the assessment reference period that had no impact on residents or others. No rejection of care was noted during the assessment reference period.

An interview was conducted with Resident #132 on 04/26/21 at 11:05 AM. Resident #132 stated, Resident #40 "comes in my room all the time and it drives me insane." Resident #132 proceed to say that her current room used to be Resident #40's room and that was why she kept coming back into her room, but she did not like it and did not want Resident #40 wandering into her room.

An interview was conducted with Nurse Aide (NA) #5 on 04/28/21 at 11:21 AM. NA #5 confirmed that she routinely worked the unit where Resident #4, Resident #34, Resident #132, and Resident #40 resided. She stated that Resident #40 did wander and could get a little aggressive at times. NA #5 stated that the staff tried to catch Resident #40 before she entered other residents rooms but didn't always catch her in time. NA #5 stated she had not heard Resident #4, Resident #34, or Resident #132 complain about Resident #40 but stated "she does wander a lot on the unit."

An interview was conducted with Nurse #1 on 04/28/21 at 5:03 PM. Nurse #1 stated that she worked on the unit where Resident #4, Resident #34, Resident #132, and Resident #40 resided during the night shift. She stated that Resident #40 was the same on night shift as she was on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 day shift. Resident #40 stuck close to Nurse #1 and would only lay down for an hour then was back up. I have heard complaints from Resident #34 that she did not like Resident #40 being in her room so we do try to keep her out of the other residents rooms but at times we are all busy and cannot sit with Resident #40 and during those times she does wander in/out of other residents rooms. An interview was conducted with Nurse #3 on 04/29/21 at 9:44 AM. Nurse #3 confirmed that she worked on the unit where Resident #4, Resident #34, Resident #132, and Resident #40 resided. She stated that she had heard other residents complain that Resident #40 wanders into their room and sits on their bed. She stated that they do try to keep Resident #40 occupied and out of other residents' rooms. If Resident #40 wandered into other residents' rooms she was generally easily redirected and really likes for someone to sit with her, so we all take turns sitting with her and keeping her occupied. An interview was conducted with the Unit Manager (UM) on 04/29/21 at 11:55 AM. The UM stated that Resident #40 was a handful and was very clingy with the staff but did wander on/off the unit. She likes to be around people so if she hears people she will generally wander into that area. The UM stated she attempted to keep a mask on Resident #40 when she was out of her room, but she would not leave it in place. She added she had not heard complaints from other residents about Resident #40 but stated "it is not fair to those residents to have to keep their door shut" and we could offer them a room change. The UM stated she thought the facility was working on a discharge for Resident #40 but in	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 the meantime, they continue to try and redirect her and to keep her out of other residents rooms. An interview was conducted with the Assistant Director of Nursing (ADON) on 04/29/21 at 1:56 PM. The ADON stated that Resident #40 wandered on/off the unit and someone would redirect her back to the unit. The ADON stated she "did not feel like anyone was angered by" Resident #40 being in their room. She did say that Resident #132 threw an object out in the hallway to get the staff's attention because Resident #40 was in her room. The ADON added "I knew she was in their rooms but not in their stuff" but stated she would try to keep Resident #40 out of those rooms. An interview was conducted with the Administrator and Director of Nursing (DON) on 04/29/21 at 2:38 PM. The Administrator stated that Resident #40 was much better than she used to be, and they were planning a discharge in the near future for Resident #40. The DON stated Resident #40 sat with a lot of the staff in their offices but at times did wander on/off the unit. She added that Resident #40 wanted someone with her at all times. The DON also stated that they had not heard any complaints until this week. The Administrator stated she would expect all the residents to have their privacy respected and if they wish for Resident #40 to not be in their room then we need to make that happen.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 690	Continued From page 40 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and facility staff interviews, the facility failed to ensure a resident's catheter tubing was off the floor resulting in the resident rolling her bedside tray over the tubing for 1 of 3 residents reviewed for catheters (Resident #13).	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Resident #13 catheter tubing was secured off the floor.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 690	Continued From page 41 Findings included: Resident #13 was admitted to the facility on 04/12/19 with diagnoses that included neuromuscular dysfunction of bladder. Review of Resident #13's physician orders 04/13/19 revealed orders that included: - Monitor placement of catheter to be in place and draining. A review of Resident #13's annual Minimum Data Set Assessment dated 02/01/21 revealed her to be moderately impaired for daily decision making. She was coded as having an indwelling catheter. Review of Resident #13's care plan last reviewed on 02/01/21 revealed a care plan for [Resident] has a catheter. An observation completed on 04/26/21 at 11:44 AM revealed Resident #13 to be sitting on the side of her bed crocheting. Her catheter tubing was observed to run down her leg and rest on the floor before rising up and back to the collection bag. While speaking with Resident #13 about her care, Resident #13 was observed maneuvering her bedside tray table and in the process, inadvertently rolled the table over her catheter tubing that was resting on the floor. The catheter bag was observed to be hooked to the Resident #13's bedside. During an interview with Nurse Aide (NA) #1 on 04/29/21 at 1:23 PM, she reported that Resident #13 completes all catheter care herself and stated she did not check and verify the tubing remained off of the floor. She verified that she was aware that Resident #13's catheter bag was	F 690	All residents with catheters have the potential to be affected by this deficient practice. On 5/3/2021 an audit was conducted of residents with catheters to insure no tubing was on the floor. No other issues were found. Reeducation will be provided to nursing staff regarding proper placement of Foley catheter tubing. This education will be included for all new nursing hires. This education will be completed by 5/26/2021. The Director of Nursing/Assistant Director of Nursing will audit 5 residents with Foley catheters weekly for 12 weeks to insure proper catheter tubing placement. Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	**542 ALLRED MILL ROAD MOUNT AIRY, NC 27030**

(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 690	Continued From page 42 required to be off the floor and did monitor that when Resident #13 was out of her room. An interview with the Assistant Director of Nursing on 04/29/21 at 4:10 PM, she reported catheter tubing should be kept off of the floor and that she will ensure that the issue will be addressed and corrected before the end of the day.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 43 Based on observations, record reviews and staff interview the facility failed to remove expired medication from 1 of 1 medication rooms and 2 of 4 medication carts (Cart C and Cart D) reviewed for expired medication. The findings included: 1. An observation of the medication room with the Unit Manager (UM) was made on 04/27/21 at 10:20 AM. The observation revealed 2 unopened bottles of Vitamin D that expired 02/20 that were in the supply cabinet and available for use. An interview was conducted with the UM on 04/29/21 at 12:18 PM. The UM stated that it was all nursing responsibility to check the stock medication for expiration dates. She stated that they had someone who checked the new stock coming in but as far as what was in the medication room it would be everyone's responsibility to make sure nothing was expired. The UM stated that with the COVID pandemic she was not sure who was or if anyone was checking them currently. An interview was conducted with the Assistant Director of Nursing (ADON) on 04/29/21 at 1:52 PM. The ADON stated that if expired medications were found in the medication room they would be returned to the pharmacy for destruction. She stated the nurses should be checking expiration dates on the medication when they pull it from the medication room. An interview was conducted with Director of Nursing (DON) on 04/29/21 at 2:46 PM. The DON stated that they had asked the pharmacy to come and take a look at the medication room and carts	F 761	F761 Label/Store Drugs and Biologicals All identified expired medications were removed from the facility and returned to the pharmacy. All residents have the potential to be affected by this deficient practice. All medication carts and medication storage rooms were checked for expired medications. No other issues were noted. Inservice related to the expired medications, including the impact it could cause and the process of removing it from the facility, was conducted by the Pharmacy Consultant for all licensed nursing staff, including all Medication Aides, on 5/10/2021. This education will be provided to new hired nurses during orientation by the Staff Development Coordinator. Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Unit Coordinator will audit medication carts and medication storage room once weekly for 12 weeks using expired Medication monitoring tool to identify expired medications, then weekly checks by nursing staff will resume. Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 44	F 761		

last week to help them get back in their routine of checking both the medication room and carts routinely. The DON stated she had not gotten any report or word that the pharmacist had found any concerns. The DON did say she expected the expired medications to be removed from the medication room and returned to the pharmacy for destruction.

2.a. An observation of Medication Cart C was made on 04/27/21 at 11:05 AM along with Nurse #3. The observation revealed the following were on the medication cart and available for use:

· A card of Zofran (antinausea medication) 4 milligrams (mg) with 14 pills that expired 11/20/20.
· A card of Zofran 4 mg with 22 pills that expired 11/20/20.
· A bottle of Vitamin D 400 units that expired on 01/21 and was opened on 03/02/21.
· A card of Catapres (blood pressure medication) 0.1 mg with 37 pills that expired 11/30/20.
· A card of loperamide (antidiarrheal medication) 2 mg with 26 pill that expired 03/31/21.
· A bottle of Antacid tablets 500 mg that expired May 2019 and was opened on 04/23/21.

An interview was conducted with Nurse #3 on 04/27/21 at 11:15 AM. Nurse #3 stated that she believed the expiration date was to be checked by the hall nurse. She stated she was handed the Antacid tablets just a few days ago and it was already out of date and she stated that "was so frustrating." Nurse #3 stated she had not noticed the other expired medication that was on the cart.

A follow up interview was conducted with Nurse #3 on 04/29/21 at 10:32 AM. She again stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 45	F 761		

that she had just got the medications from the stock room and they were already out of date. She stated she assumed that the staff member that ordered the medication was also checking the expiration dates on the stock medication. Nurse #3 stated that the medication that was on the cart was the hall nurse's responsibility even though she did not have the time to check her cart. She added it had been a while since she had checked the medication cart for expired medication.

2.b. An observation of Medication Cart D was conducted on 04/28/21 at 4:47 PM along with Nurse #4. The observation revealed the following medications were on the cart and available for use:

· A card of Metoprolol (blood pressure medication) 50 milligrams (mg) with 30 pills in it that expired 11/20.
· A card of Zofran (antinausea medication) 4 mg with 6 pills in it that expired 12/31/20.
· A card of Meclizine (antiemetic medication) 12.5 mg with 29 pills in it that expired 03/31/21.
· A card of Ondansetron (antiemetic medication) 4 mg with 18 pills in it that expired 01/31/21.
· A card of Zofran 4 mg with 7 pills in it that expired 01/02/21.
· A card of Carbidopa-Levodopa (used for Parkinson's disease) 25/100 mg with 60 pills in it that expired 03/31/21.
· A card of Meclizine 12.5 mg with 22 pills in it that expired on 01/31/21.
· A card of Neurontin (used to treat neuropathy) 100 mg with 60 pills in it that expired on 01/3/21.
· 7 cards of Metoprolol that had 30 pills in each card that expired on 02/28/21.
· A card of Zofran 4 mg with 80 pills in it that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 46	F 761		

expired on 01/01/21.

An interview with Nurse #4 was conducted on 04/28/21 at 4:56 PM. Nurse #4 stated that it was the responsibility of the hall nurse to check the medication carts for expired medication and then to give them to the Unit Manager (UM). Nurse #3 stated that when she reported to work, she had not gone through her medication cart for expired medication. She stated sometimes they had the time to do so and sometimes they did not.

An interview was conducted with the UM on 04/29/21 at 12:18 PM. The UM stated she was not aware that the cards of medication had an expiration date on them and that this had "been a learning experience" for her. The UM stated that with the COVID pandemic she was not sure who was or if anyone was checking them currently.

An interview was conducted with the Assistant Director of Nursing (ADON) on 04/29/21 at 1:52 PM. The ADON stated the medication carts should be checked once a week by the hall nurse but added they should be checking the expiration date before they administer the medication. The ADON stated that the administrative nurses could help with going through the medication carts if needed but stated she had not recently gone through any medication cart. If expired medications were noted, it should be removed from the cart and returned to the pharmacy for destruction.

An interview was conducted with Director of Nursing (DON) on 04/29/21 at 2:46 PM. The DON stated that they had asked the pharmacy to come and take a look at the medication room and carts last week to help them get back in their routine of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	**542 ALLRED MILL ROAD MOUNT AIRY, NC 27030**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 47 checking both the medication room and carts routinely. The DON stated she had not gotten any report or word that the pharmacist had found any concerns. The DON did say she expected the expired medications to be removed from the medication room and returned to the pharmacy for destruction.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		5/26/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 880	Continued From page 48 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to	F 880	F880 Infection Prevention & Control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SURRY COMMUNITY HEALTH AND REHAB CENTER	542 ALLRED MILL ROAD MOUNT AIRY, NC 27030

(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 880	Continued From page 49 ensure staff donned personal protective equipment (PPE) before entering a room of a resident on Contact Precautions and perform hand hygiene before exiting the room for 3 of 3 staff members (Nurse Aide #1, Nurse Aide #2, and Training Nurse Aide #1). 2)The facility failed to implement a policy to ensure visitors were screened in the lobby before entering the facility according to the Center for Disease Control and Prevention (CDC) and Center for Medicare and Medicaid Services (CMS) recommendations prior to entering the facility for 6 of 6 visitors (4 surveyors and 2 family members). These failures in infection control practices occurred during a COVID-19 pandemic. Findings included: A review of a facility document titled "Infection Prevention Manual for Long Term Care" revised 04/2021 under a section headed Contact Precautions indicated hand hygiene should be completed prior to donning gloves and gloves should be worn when entering the room and while providing care for the resident. The document further indicated gloves should be changed after having contact with infective material and should be removed before leaving the resident's room and hand hygiene should be performed immediately. It revealed a gown should be donned prior to entering the room or resident cubicle and the gown should be removed before leaving the resident's room. 1.a. An observation on 04/26/21 at 3:54 PM revealed Nurse Aide (NA) #1 and Training Nurse Aide (TNA) #1 entered the room of Resident #287. The door of Resident #287 revealed signage which indicated she was on	F 880	On April 26, 2021 during annual survey it was noted nurse aide #1and #2 and TNA #1 failed to perform hand hygiene and failed to don and doff appropriate PPE for contact isolation. On April 26, 2021 four surveyors entered the building and did not complete a screening tool. On April 12, 2021 two family visitors entered the building without completing screening tools. All residents have the potential to be affected by this deficient practice. Nursing administration went to these staff members upon being made aware and began reeducation. All residents have the potential to be affected by this deficient practice. Screening tools are provided and review prior to visitation. Screens were made readily available at check in desk. Reeducation was initiated for all staff on hand hygiene and donning and doffing PPE. This education is provided to all new hires during orientation. This education will be completed by 5/26/2021. One to one education was provided to Unit Manager and reeducation to all staff on proper visitor screening and will be completed by 5/26/2021. Assistant Director of Nursing/DON will randomly audit up to 3 residents weekly on contact isolation for 12 weeks. Assistant Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and	

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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F 880	Continued From page 50 transmission-based Contact Precautions. NA #1 was observed to wear a face mask and goggles and TNA #1 wore a face mask and a face shield, but neither were observed to don a gown or gloves before they entered the room or before they approached Resident #287's bed where each placed themselves along one side of Resident #287. NA #1 and TNA #1 each placed their arms under Resident #287 shoulder and performed bed mobility to assist Resident #287 up in the bed. NA #1 then repositioned the sheet to cover Resident #287 and both exited the room without performing hand hygiene and they entered the room directly across the hall. An interview on 4/29/21 at 3:30 PM with NA #1 and TNA #1 revealed both recalled assisting Resident #287 with bed mobility on 04/26/21. Each indicated on 04/26/21, they noticed Resident #287 had slid down in the bed and needed to be pulled up so they overlooked the signage that indicated Contact Precautions and entered without donning PPE which was illustrated on the Contact Precaution sign on Resident #287's door. Each stated they had been educated on infection control, transmission-based precautions, and PPE and were aware Resident #287 was on Contact Precautions but failed to don a gown or gloves before they touched Resident #287 and surfaces in her room and failed to perform hand hygiene before they exited the room and entered another resident's room who was not on Contact Precautions. An interview on 04/29/21 at 12:00 PM with the Director of Nursing (DON) revealed all nursing staff had received ongoing training on transmission-based precautions, hand hygiene, and PPE and were all knowledgeable of best	F 880	recommendations as indicated. Director of Nursing/ADON will reconcile visitor screening tools 5 days a week in clinical startup for 12 weeks. Director of Nursing will present the results of these findings to the QAPI meeting to evaluate effectiveness. The QAPI committee will make changes and recommendations as indicated.	

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	345191	A. BUILDING ______ B. WING ______	C 04/29/2021

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F 880	Continued From page 51 practices for infection control. The DON stated NA #1 and TNA #1 should have donned a gown and gloves before entering Resident #287's room and assisting her with bed mobility as well as performed hand hygiene before they exited the room. The DON explained she expected all staff who entered Resident #287's room to follow the instructions listed on the signage on the resident's door. An interview on 04/26/21 at 4:30 PM with the Administrator revealed all staff had received education on transmission-based precautions, hand hygiene, and PPE and were expected to follow the instructions illustrated on the signage outside the resident's room. She acknowledged staff who enter a resident's room on Contact precautions should wear a gown and gloves in addition to the facility's current COVID-19 PPE precaution of a face mask and eyewear and should perform hand hygiene before and after entering the room. 1. b. An observation on 04/26/21 at 4:00 PM revealed Resident #76 was hollering out for NA #2 who ambulated in the hallway outside Resident # 76's room. Resident #76's door indicated she was on transmission-based precautions of Contact Precautions. NA #2 was observed to enter Resident #76's room while she wore a face mask and eyewear but was not observed to don a gown or gloves before she approached her bed to respond to her hollering out. NA #2 was observed to pull the curtain approximately halfway down Resident #76' bed and then observed to pull a sheet to cover Resident #76. NA #2 then approached the sink to perform hand hygiene and she noticed a feces soiled washrag had been left under the sink and	F 880		

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F 880	Continued From page 52 she proceeded to apply a glove, pick up the washrag, and she exited the room where she placed the washrag in the soiled linen receptacle in the hallway. NA #2 was not observed to perform hand hygiene after contact with Resident #76. Immediately following the observation and during an interview with NA #2 on 04/26/21 at 4:15 PM, NA #2 was observed to enter and exit Resident #76's room three times without donning a gown or gloves or performing hand hygiene while she explained and demonstrated to the surveyor her recollection of the observation on 04/26/21 at 4:00 PM. During the interview, NA #2 was observed to touch the bedside table, the curtain, and the sink without the gown or gloves illustrated on the Contact Precaution sign. An interview on 04/26/21 at 4:15 PM with NA #2 revealed she had entered Resident #76's room after she was heard hollering out for her from the hallway. NA #2 stated she wore a face mask and eyewear but forgot to don a gown or gloves before she touched Resident #76 or environmental surfaces in the room and became distracted when she noticed the soiled washrag which resulted in her not completing hand hygiene when she exited Resident #76's room. NA #2 acknowledged she had received education on infection control practices to include transmission-based precautions, hand hygiene, and PPE and was aware Resident #76 was on Contact Precautions. NA #2 also explained she did not think to apply a gown or gloves while she demonstrated the occurrence to the surveyor during an interview. An interview on 04/29/21 at 12:00 PM with the	F 880		

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F 880	Continued From page 53	F 880		

Director of Nursing (DON) revealed all nursing staff had received ongoing training on transmission-based precautions, hand hygiene, and PPE and were all knowledgeable of best practices for infection control. The DON stated NA #2 should have donned a gown and gloves before she entered Resident #76's room and assisted her as well as performed hand hygiene before she exited the room. The DON explained there should not have been a soiled washrag in the floor under the sink and NA #2 should have bagged the rag before she exited the room then performed hand hygiene immediately following. The DON explained she expected all staff who entered Resident #76's room to follow the instructions listed on the signage on the resident's door. The DON acknowledged NA #2 should have donned a gown and gloves when she performed a demonstration in Resident #76's room during an interview with the surveyor on 04/26/21.

An interview on 04/26/21 at 4:30 PM with the Administrator revealed all staff had received education on transmission-based precautions, hand hygiene, and PPE and were expected to follow the instructions illustrated on the signage outside the resident room. She acknowledged staff who enter a resident room on Contact precautions should wear a gown and gloves in addition to the facility's current COVID-19 PPE precaution of a face mask and eyewear and perform hand hygiene before and after entering the room..

2. A review of the facility document titled "Screening Process for Visitors" dated 04/15/21 indicated a license nurse would screen all visitors at each visit to include a screening tool which

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F 880	Continued From page 54	F 880		

included specific questions regarding the presence of symptoms and potential exposure to COVID-19. A) Individuals that screen positively for symptoms and/or fever or a combination of fever, respiratory symptoms or others identified on the screening tool; B) individuals with a confirmed diagnosis of COVID-19 or under investigation for COVID-19. The document further indicated as part of the screening process, visitors will identify whether they have worked in a nursing center, medical office, or other healthcare setting that had confirmed COVID-19 cases in the past 14 days and this information will be evaluated as part of the screening process. A further review of the document under a section titled "Surveyor Entry" indicated in the event of surveyor entry, conduct the visitor screening, but if the surveyor indicated that they had potential or known contact with COVID-19 and used PPE appropriately during that contact, the surveyor was considered low risk of transmission and must be granted success. Document the findings of the screening and the statement of the proper use of PPE on the screening form. Surveyors may not enter the center if they have a fever and surveyors are not required to be vaccinated to enter the center.

An observation on 04/26/21 that began at 9:30 AM and ended at 10:30 AM revealed 4 visitors (survey team) entered the front entrance to the facility and were greeted by the Unit Manager who asked their first name, obtained their temperature, and recorded these on a log form in the front lobby before the visitors were approached and escorted to a community dining room by the Administrator.

An interview on 04/29/21 at 10:19 AM with two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 55 family members revealed they entered the facility on 04/12/21 to visit a resident. They both indicated they were greeted at the front door by a staff member who obtained their temperature, but neither were asked to complete a COVID-19 screening questionnaire or asked to sign the acknowledgement of education being provided regarding COVID-19. One of the two family members indicated they returned to the facility on 04/27/21 and was again not asked to complete a COVID-19 screening questionnaire, asked to sign acknowledgement of education being provided regarding COVID-19 and was not handed the COVID-19 screening questionnaire until she exited the facility. An interview on 04/29/21 at 12:30 PM with the Nurse Unit Manager (UM) revealed although no one was assigned to perform visitor screenings, she typically greeted and performed screening tasks for visitors who entered the facility through the front door because she was the staff member who usually overheard the doorbell. The UM stated she was taught to log the visitors name and obtain their temperature on the COVID-19 visitor log and provide each visitor with a screening form to complete before they could enter the facility. The UM indicated on 04/26/21 when the survey team entered the facility, there were no screening forms available at the receptionist table which was located just inside the lobby door. The UM further revealed she was also the staff member present at the front desk when the two family members entered the facility on 04/12/21 and she did not ask either family member to complete a COVID-19 screening questionnaire before entering the facility nor had she asked the family member to complete a COVID-19 screening questionnaire prior to	F 880		

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F 880	Continued From page 56 entering the facility on 04/27/21. The UM elaborated she had filled out the screening questionnaires for each visitor herself and wrote the visitors name on the document on the visitor signature line which indicated acknowledgement by the visitor they had received education regarding COVID-19 and the document was not provided to a visitor for completion to include their personal signature. An interview on 04/29/21 at 12:00 PM with the DON revealed all visitors should be screened before they entered the facility to include being provided a CDC COVID-19 screening questionnaire to complete and sign, a temperature check, and each visitors name and temperature should be written on the visitation log at the front desk. She was unsure why the COVID-19 screening questionnaires were not provided to the surveyors on 4/26/21 when they entered the facility or the family members on 4/12/21 and 4/27/21 nor evaluated by the UM before they were allowed to enter the facility. An interview on 04/29/21 at 4:00 PM with the Administrator revealed all visitors were to be screened at the front desk before they entered the facility. The screening was to include a temperature check, visitor's name and temperature recorded on the visitation log, as well as each visitor should be provided a COVID-19 screening questionnaire to complete with their signature included and the form should be reviewed by a staff member before the visitor was allowed to enter the facility. The Administrator acknowledged she was aware of a family member who had notified her she was not properly screened before she entered the facility. She also stated she understood a staff member	F 880		

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F 880	Continued From page 57 could not sign the visitor's signature without the visitor's knowledge on the COVID-19 screening questionnaire as acknowledgement of education being provided related to COVID-19, it must be signed by the visitor.	F 880		