STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wadesboro Health & Rehab Center	2051 Country Club Road Wadesboro, NC 28170

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record reviews and staff interviews, the facility failed to complete an annual comprehensive assessment within the required time frame (Resident #29) for 1 of 15 sampled residents. The findings included: Resident #29 was admitted to the facility on [DATE]. A review of Resident #29's Minimum Data Set (MDS) assessments revealed an admission MDS completed on 5/4/24, and Quarterly MDS assessments completed on 8/4/23, 11/4/23, 2/4/24 and 5/6/24. The annual assessment was not completed. On 6/25/24 at 11:10 AM, an interview occurred with the MDS Nurse #1. She reviewed the MDS assessments that had been completed for Resident #29 and stated that the quarterly MDS assessment that was completed on 5/6/24 should have been an annual assessment. She further explained the facility had recently transitioned to a new Electronic Medical Record (EMR) system in April 2024 and felt it was an oversight due to the transition that another quarterly assessment was completed instead of an annual assessment. The Administrator was interviewed on 6/25/24 at 1;30 PM and stated that she would expect the annual MDS assessment to be completed in the required time frame for Resident #29.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on staff interviews and record review, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of trach care (Resident #17), prognosis (Resident #47), discharge (Resident #63), and medication (Resident #41 and #55). This was for 5 of 17 residents reviewed for MDS accuracy. The findings included: 1. Resident #17 was admitted to the facility on [DATE] with diagnoses that included a tracheostomy. The quarterly MDS assessment dated [DATE] indicated Resident #17 ' s cognition was intact. The special treatments, procedures, and programs section for tracheostomy care while a resident was not coded. Review of Resident #17 ' s active orders revealed an order that read in part to change inner cannula of trach daily for infection control, the medication administration record (MAR) was signed daily as being completed. Another order read to change trach ties weekly on Tuesdays for infection control, the MAR was signed every Tuesday as being completed. An interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #1. She verified Resident #17 had a tracheostomy and that she did not code the special treatments, procedures, and programs section. She stated it was an oversight that she did not code tracheostomy care on his MDS assessment. An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded. 2. Resident #47 was admitted to the facility on [DATE] with diagnoses that included Dementia Disorder. Record review revealed Resident #47 started receiving Hospice services on 08/17/22. Review of Resident #47 ' s orders revealed an order that read in part that resident was admitted to Hospice Services for significant decline in overall health and a decline in status was expected related to terminal illness. Resident #47's active care plan, last revised on 02/28/24, included a focus area that read Resident #47 was on Hospice services for significant decline in overall health. Has expected to decline in status related to terminal illness. The interventions included for staff to contact hospice for changes in resident condition and to keep resident comfortable. The quarterly MDS assessment dated [DATE] indicated Resident #47 ' s cognition was severely impaired. The health conditions section for Resident #47 under prognosis was coded as not having a condition or chronic disease that may result in a life expectancy of less than 6 months although she was coded as receiving Hospice services while being a resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #1. She verified Resident #47's Health Conditions section for terminal prognosis was coded as No. She stated she was aware Resident #47 was being followed by Hospice and it was an oversight that she miscoded this question. She verified the resident was covered by Hospice and had a life expectancy of 6 months or less. An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded. 3. Resident #63 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus and closed fracture with routine healing. The discharge MDS assessment dated [DATE], identification information section under discharge status indicated Resident #63 was discharged to a short-term general hospital. Review of a Nursing Progress Note dated 04/15/24 revealed that Resident #63 was discharged home with son. Review of Discharge Summary, dated 04/15/24, revealed Resident #63 was discharged home with family. An interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #1. She verified Resident #63's Identification Information section under discharge status was coded as being discharged to a short-term general hospital. She stated she was aware Resident #63 was discharged home and it was an oversight that she miscoded this question. An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded. 4. Resident #41 was admitted to the facility on [DATE] with diagnoses that included essential (primary) hypertension and primary pulmonary hypertension. Review of Resident #41 ' s active orders revealed an order for furosemide (used to treat high blood pressure (hypertension), heart failure and a buildup of fluid in the body) 40 milligram (mg) tablet once a day, 1 tablet, with a start date of 04/10/24. The admission MDS assessment dated [DATE] indicated Resident # 41 was not coded for diuretics. An Interview was conducted on 06/25/24 at 1:45 PM with MDS Coordinator #2. She verified she did not code that Resident #41 received diuretics during the look back period of his admission assessment. She stated she overlooked Resident #41's diuretic medication order when she was completing his assessment. It was an oversight that she did not code the diuretic on his MDS assessment. An Interview was conducted on 06/25/24 at 2:20 PM with the Administrator. She stated she expected the MDS assessments to be accurately coded and that care plans should be patient centered. 40197 5. Resident #55 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and dementia with mood disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A review of Resident #55's physician orders included orders dated 3/26/24 for Trazodone (an antidepressant medication) 50 milligrams one tablet by mouth once a day and Duloxetine (an antidepressant medication) 30 milligrams three capsules by mouth one a day. A review of the May 2024 Medication Administration Record (MAR) showed that Resident #55 received the antidepressant medications during the 7-day look back period for the 5/9/24 MDS assessment (5/3/24 through 5/9/24). A review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] did not have antidepressant medications coded. b. A review of Resident #55's physician orders included an order dated 5/1/24 for Macrobid (an antibiotic) 100 milligrams 1 capsule by mouth twice a day with a stop date of 5/8/24. A review of the May 2024 MAR showed that Resident #55 received the antibiotic medication during the 7-day look back period for the 5/9/24 MDS assessment (5/3/24 through 5/8/24). A review of the quarterly MDS assessment dated [DATE] did not have antibiotic medications coded. On 6/25/24 at 10:50 AM, an interview occurred with MDS Nurse #1 and #2, who reviewed the MDS assessment dated [DATE] as well as Resident #55's medical record. MDS Nurse #1 stated she failed to include the antidepressant and antibiotic medications on the assessment and felt it was an oversight. Both MDS Nurse #1 and #2 stated the MARs should be reviewed carefully to code the medication section of the MDS assessment accurately. The Administrator was interviewed on 6/25/24 at 1:30 PM and stated she would expect the MDS assessments to be accurately.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40197 Based on record review and staff interviews, the facility failed to develop a comprehensive care plan for the presence of a nephrostomy tube (a tube that let's urine drain from the kidney through an opening in the skin on the back-Resident #2), and a skin condition (Resident #34). This was for 2 of 15 resident care plans reviewed. The findings included: 1) Resident #2 was originally admitted to the facility on [DATE]. She was hospitalized from 2/19/24 to 2/29/24 and found to have a complex urinary tract infection due to a kidney stone. At that time a left sided nephrostomy tube was placed. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 had severe cognitive impairment. She was coded with an indwelling catheter. Review of the active care plan, last revised 6/14/24, did not include the presence of a nephrostomy tube. On 6/25/24 at 10:50 AM, an interview occurred with MDS Nurses #1 and #2 who reviewed Resident #2's active care plan. They confirmed a care plan was not developed for the presence of a nephrostomy tube but should have been and stated it was an oversight. The Administrator was interviewed on 6/25/24 at 1:30 PM and stated it was her expectation for the care plan to be person centered and should have included the presence of the nephrostomy tube for Resident #2. 2) Resident #34 was admitted to the facility on [DATE]. A physician progress note dated 4/25/24 indicated Resident #34 was seen for skin lesions to the scalp and left ear and had a history of skin cancers to his head in the past. A referral was made to dermatology. A review of Resident #34's medical record revealed he was seen by the dermatologist and had a procedure completed to remove skin cancer lesions to his scalp and left ear on 5/21/24. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #34 was cognitively intact and was coded for open lesions other than ulcers, rashes or cuts. A review of the May 2024 physician orders included an order dated 5/24/24 to cleanse the scalp and left ear gently with soap and water twice a day and apply a thin layer of Vaseline. Review of the active care plan, last revised 5/31/24, did not include the skin condition to Resident #34's scalp and left ear. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/24 at 10:50 AM, an interview occurred with MDS Nurse #1 and #2 who reviewed Resident #34's active care plan and MDS assessment dated [DATE]. They confirmed a care plan was not developed for the skin condition to Resident #34's scalp and left ear but should have been and stated it was an oversight. The Administrator was interviewed on 6/25/24 at 1:30 PM and stated it was her expectation for the care plan to be person centered and should have included the skin condition to Resident #34's scalp and left ear.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281 Based on record review, observations, and staff interviews, the facility failed to change a gastrostomy tube dressing site that was ordered to be completed daily for 1 of 2 residents reviewed for gastrostomy tubes (Resident #31). The findings included: Resident #31 was admitted to the facility 1/9/2024 with diagnoses including stroke and gastrostomy tube for feeding. Resident #31's medical record was reviewed, and a physician order dated 4/25/2024 ordered for daily gastrostomy site dressing to be completed by cleaning the site and applying clean gauze. The quarterly Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #31 was severely cognitively impaired, and he received tube feeding nutrition daily. The treatment record for Resident #31 indicated the gastrostomy tube dressing change had been changed on 6/22/2024 and 6/23/2024. Resident #31 was observed on Monday 6/24/2024 at 2:05 PM. A gastrostomy tube with a dressing was noted and the dressing was dated Friday 6/21/2024. The gastrostomy dressing appeared to be wet with a clear, light yellow, odorless drainage. Nurse #1 was interviewed at the time of the observation, and she reported the gastrostomy dressing was ordered to be changed daily and she was going to change the dressing in a few minutes. The Director of Nursing (DON) was interviewed on 6/24/2024 at 2:17 PM. The DON explained that the weekend supervisor was responsible for completing all treatments in the facility during the weekend. The DON reported the dressing should have been changed by the weekend supervisor. MDS Nurse #1 was interviewed on 6/25/2024 at 9:03 AM. MDS Nurse #1 reported she was responsible for the treatments and wound care on the weekend as the weekend supervisor. MDS Nurse #1 ran a report of the treatments that were due for Resident #31 and the gastrostomy dressing change was not on the report. MDS Nurse #1 explained that she was not aware the gastrostomy dressing needed to be changed and she would have changed the dressing if it was on her report. The Administrator was interviewed on 6/25/2024 at 1:23 PM and she reported the gastrostomy dressing change was not entered into the electronic medical record as a treatment and the dressing change was not completed by the weekend supervisor. The Administrator reported she expected gastrostomy dressing changes to be added to the treatment plan so dressing changes were not missed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46095 Based on observations, and staff interviews the facility failed to discard opened food items ready for use within 7 days of opening in 1 of 1 walk-in refrigerators and in 1 of 2 reach-in refrigerators. The facility also failed to label, and date opened food items in 1 of 1 walk-in refrigerators and in 1 of 2 reach-in refrigerators. This practice had the potential to affect food served to residents. The findings included: Observations during the initial tour of the main kitchen with Dietary Cook/Aide #1 on [DATE] at 10:55 AM, revealed the following: a. In the walk-in refrigerator the following items were observed. -32 oz pack (,d+[DATE] full) sliced Virginia baked ham-no open date. -21 hot dogs in a zip lock bag with an opening date of [DATE]. -Twelve 8 ounce (oz) bowls with a yellow pudding like substance in them that were not dated and were not covered. - Forty-eight 8 oz bowls with a yellow pudding like substance in them were not dated. b. In the reach-in refrigerator #1 the following items were observed. -2 pounds of sliced turkey with no open date. -,d+[DATE] of quart sized zip lock bag with sliced onions with an opening date of [DATE]. -,d+[DATE] of a gallon size zip-lock bag with sliced cheese with no open date. -3-pound container of Pimento cheese spread with an opening date of [DATE]. On [DATE] at 10:55 AM an interview was conducted with Dietary Cook/Aide #1. She stated the Dietary Manager (DM) checks the coolers and freezers for undated foods and expired food, use by dates. She also stated she was unaware how many days items could be stored in the coolers before discarding them. She verified staff were to label and date items after opening or preparing. Dietary Cook/Aide #1 discarded the above items at the end of the initial tour. On [DATE] at 10:59M an interview was conducted with Dietary [NAME] #2, and Dietary Aide #1. They both stated they were unaware how many days items could be stored in the coolers before discarding them. They verified staff were to label and date items after opening or preparing. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:10 PM an interview was conducted with the Dietary Manager (DM). She verified all items that were not dated or had not been removed within 7 days had been discarded. She stated she forgot to date the sliced lunch meat in the coolers and did not remove the dated food items that were unused after 7 days. A follow-up interview was conducted on [DATE] at 10:56 AM with the Dietary Manager (DM). She stated she was the only one responsible for monitoring the freezer and coolers for food dates and labels. She also stated she tries to check the opened items and discard dates daily or at least every other day. She indicated she had been having staffing issues lately and she had been covering shifts. She also indicated she had forgotten to check the coolers and freezers. She then stated, I dropped the ball on it, I just have to make it right now. She then stated that the kitchen cooks and aides are to put the food in an airtight container/baggy and write their initials and open date on the containers. She then stated she needed to reeducate staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37281 Based on record review, observations, and staff interviews, the facility failed to implement the facility's policy for enhanced barrier precautions for 1 of 11 residents reviewed for infection control (Resident #31). The findings included: The facility infection control policy with a revision date of 4/15/2024 read, in part: Enhanced Barrier Precautions are intended to prevent the transmission of multi-drug resistant organisms via contaminated hand and clothing of healthcare workers to high-risk residents. Resident #31 was observed in bed on 6/23/2024 at 10:52 AM. There was no sign on the door indicating EBP were in place and no caddy with Personal Protective Equipment (PPE) outside of his door. Resident #31 was noted to have tube feeding (on hold) and a wound dressing was noted to his left lower leg. Incontinence care for Resident #31 was observed with Nursing Assistant (NA) #1 and NA #2 on 6/24/2024 at 2:03 PM. NA #1 and NA #2 performed hand hygiene and applied gloves but did not don gowns to provide incontinence care to Resident #31. When asked if providing incontinence care for Resident #31 required any additional PPE, NA #1 stated there was not a sign on the door, so there was no need for additional PPE. Nurse #1 was interviewed on 6/24/2024 at 2:05 PM. Nurse #1 explained because Resident #31 had a chronic wound and a gastrostomy tube, he should have EBP in place and the NAs should have worn appropriate PPE to provide care. Nurse #1 explained the signs on the door and the PPE carts outside the door communicated to staff and visitors that EBP were in place for residents. The Infection Control nurse was interviewed on 6/24/2024 at 2:10 PM and she reported that due to Resident #31's wound and gastrostomy tube, the NAs should have applied gowns and gloves to provide incontinence care. The Infection Control nurse explained that when Resident #31 was moved to his current room the sign for EBP was not moved with him. The Infection Control nurse reported the signs on the door and PPE carts communicated to staff and visitors that EBP were in place. An interview was conducted with the Director of Nursing (DON) on 6/24/2024 at 2:17 PM. The DON explained any resident with an indwelling device, such as a gastrostomy tube for feeding, and/or a chronic wound should have Enhanced Barrier Precautions implemented to prevent the transmission of pathogens or possible contamination of the indwelling device or wound. The DON reported Resident #31 was moved from a room and the signage for EBP was not moved with him. The DON reported she expected all residents with an indwelling device or chronic wound to have a physician order for EBP, a sign on their door, and a PPE caddy available for staff to use the appropriate PPE. The DON reported EBP were communicated in report to the staff, the signs on the door, and the PPE carts by the resident rooms. The Administrator was interviewed on 6/25/2024 at 1:23 PM and she reported that staff had received infection control education and should be able to recognize when a resident required EBP.