STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE RIDGE ON THE MOUNTAIN	417 CLOVERDALE ROAD SYLVA, NC 28779

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family and staff the facility failed to notify a resident's responsible party of a newly developed	F 157	1. Resident #1□s Responsible Party was made aware of all wounds on the resident 7/27/16. Resident #1 was	9/5/16

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

Electronically Signed | 09/01/2016

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F 157	Continued From page 1 wound and of a deterioration in a resident's wound for 1 of 3 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/21/15 with diagnoses including: history of deep vein thrombosis in both lower extremities, chronic kidney disease stage 3 and coronary artery disease. The most recent assessment was a quarterly Minimum Data Set (MDS) dated 04/28/16 which indicated Resident #1 had moderate cognitive impairment and had fluctuating inattention and disorganized thinking. The MDS indicated Resident #1 had no behavioral symptoms or rejection of care and was dependent on staff for bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. Resident #1 was assessed as having 1 unstageable pressure ulcer that contained eschar and measured 3.0 X 3.0 centimeters (cm). The MDS indicated she had a pressure reducing device for bed, nutrition or hydration intervention, pressure ulcer care and application of dressings to feet. A Care Plan which was last updated on 07/26/16 addressed resident's pressure ulcers. Interventions included: monitor skin with care for any reddened, suspicious or open areas and inform nurse, pressure reduction mattress to bed and treatment as indicated by wound care. Review of physician orders revealed an order dated 07/11/16 at 8:05 PM to check dressing daily and change as needed with a non-adherent absorbent gauze dressing to left lateral lower leg	F 157	discharged from the facility on 8/9/16. 2. All residents, with limited mobility, cognition, or incontinence are at risk for this alleged deficit practice. A 100% Skin Audit of all facility residents was completed on 7/26/16 and any new wounds were reported to the resident□s Responsible Party and Physician. 3. Licensed Nurses were in serviced on 7/26/16 by the Director of Nursing regarding Notifying resident□s Responsible Party and Physician when a new wound has been observed. Facility Certified Nursing Assistants were In serviced on 7/26/16 by the Director of Nursing regarding Notifying the Licensed Nurse regarding changes in a resident□s skin condition. Wound Rounds are conducted weekly by Wound Care Nurse and Wound Care PA-C and all wounds are identified, measured, and notification made to the resident□s Responsible Party, if indicated, and to the Physician, to ensure orders for treatment are received, if indicated and recorded on QA Internal Pressure Ulcer record. Skin audits are completed on residents weekly to ensure all wounds are identified and new wounds reported to the resident□s Responsible Party and Physician. 4. The results of the Quality Improvement monitoring will be reported by the Director of Nursing/ADON/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI	

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F 157	Continued From page 2 blister. Review of nurse's notes revealed an entry dated 07/11/16 at 8:05 PM that indicated Resident #1 had a 6.0 X 9.0 centimeter (cm) dark purplish-black, draining blister located on left lateral lower leg with purplish red surrounding the blister. A nurse's note dated 07/19/16 at 5:52 PM indicated that left leg lower posterior wound developed in house due to trauma from use of donut boot. A note dated 07/26/16 at 7:03 PM indicated Resident #1 was seen by the Wound Care Specialist and new orders were received for treatment to the unstageable ulcer on resident's left heel that had dark necrotic tissue present as well as maggots. A note dated 07/27/16 at 7:54 AM revealed maggots were noted to still be in the wound on the left heel with 2 removed during the dressing change. None of the notes indicated that resident's responsible party (RP) was notified of the development of the blister on the left lower leg or of the maggots found in the pressure ulcer on the left heel. A progress note by the Wound Care Specialist dated 07/26/16 indicated Resident #1 had a pressure ulcer on her left heel that measured 5.5 X 5.5 cm with an estimated depth of 0.3 cm that was covered by excessive necrotic tissue. The note indicated that non-sterile maggots were found throughout the wound on her heel. The note also indicated Resident #1 had a trauma wound on the left lower posterior leg that measured 9.0 X 5.0 X 0.1 cm that had excessive necrotic tissue. The note indicated that both wounds were deteriorating. An interview on 08/10/16 at 10:40 AM with the RP of Resident #1 revealed he was not informed	F 157	committee will recommend revisions as indicated to sustain substantial compliance.	

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F 157	Continued From page 3 about maggots being found in the resident's wound or of the new area on the back of her leg until 07/27/16. The RP stated when he saw the wounds the bone was visible on the left heel and the back of the left leg. He described the wound on the back of the leg as being "big as my hand." An interview with Nurse #2 on 08/11/16 at 2:34 PM revealed she did not notify the RP of Resident #1 about the skin breakdown on the left lower posterior leg. An interview with Nurse #1 on 08/12/16 at 11:00 AM revealed he had not notified the RP of Resident #1 about the maggots that were found in the left heel wound. An interview with the Director of Nursing on 08/12/16 at 2:28 PM revealed she expected a resident's responsible party to be notified of a new wound, a new treatment, new orders or a change in a resident's condition the same day of the change. An interview with the Administrator on 08/12/16 at 3:52 PM revealed he expected a resident's responsible party to be notified of any change in a resident's condition by no later than the end of the shift in which the change occurred.	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		9/5/16

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, medical providers and staff the facility failed to follow wound care interventions as specified in the resident's plan of care for 1 of 4 sampled residents (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/21/15 with diagnoses including: history of deep vein thrombosis in both lower extremities, chronic kidney disease stage 3 and coronary artery disease. The most recent assessment was a quarterly Minimum Data Set (MDS) dated 04/28/16 which indicated Resident #1's cognition was moderately impaired and she had fluctuating inattention and disorganized thinking. The MDS indicated Resident #1 had no behavioral symptoms or rejection of care and was dependent on staff for bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. Resident #1 was assessed as having 1 unstageable pressure ulcer that was eschar and measured 3.0 X 3.0 centimeters (cm). The MDS indicated she had a pressure reducing device for bed, nutrition or hydration intervention, pressure ulcer care and application of dressings to feet. A Care Plan which was last updated on 07/26/16 addressed resident's pressure ulcers to her left heel and left lower posterior leg with the goals that the areas would heal or show signs of healing by the next review and she would be free from further pressure ulcers through the next review. Interventions included: treatment as	F 282	Treatments for Resident #1 were ordered daily prior to 7/26/16. Due to a significant change in wound status, treatments began twice per day on 7/26/16 after evaluation by wound care nurse and Wound Care PA-C. Wound care orders then changed to daily on 8/2/16 per Wound Care PA-C. These treatments were completed by the wound care nurse daily Monday through Friday with assessment and evaluation of current treatments of the wounds being completed with Wound Care PA-C being notified as needed. Dressing changes on Saturday and Sunday were performed by staff licensed nurses with nursing administration verifying visually that wound care dressing were clean, dry, and intact and had been dated for the appropriate treatment date. Immediate Duplex Scan of Lower Extremities Arterial was ordered and completed on 7/30/2016 showing severe left peripheral vascular disease in the left lower extremity. Based on this finding, referral and consultation with Western Carolina Vascular completed with recommendation to family for comfort care or left lower extremity above the knee amputation. Resident continued to receive wound care treatment and dressing changes daily until discharge to hospital per family request on 8/9/2016. Resident #1 was discharged on 8/9/16. 2. All residents with wounds are at risk for this alleged deficit practice. Residents	

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F 282	Continued From page 5 ordered, float heels in bed, notify physician if no improvement or worse, monitor skin with care for any reddened, suspicious or open areas and inform nurse, pressure reduction mattress to bed and treatment as indicated by wound care. Medical record review revealed Resident #1 received wound care mangement from a Wound Clinic from 04/27/16 through 06/20/16. Review of a Wound Clinic note dated 06/13/16 indicated the pressure ulcer measured 2.1 X 1.5 X 0.4 cm. Listed in the note under dressing change frequency were the following instructions: "Change dressing every day or as needed for excessive drainage." The word "every" was underlined several times. Review of a Wound Clinic note dated 06/20/16 indicated the pressure ulcer measured 2.2 X 2.1 X 0.5 cm and had increased in size with surrounding tissue and the wound was duskier. The note read in part: "needs better offloading to protect this wound." A physician's order from the Wound Care Specialist (WCS) dated 07/19/16 read: "Dakin's full strength solution applied to pressure wound left heel then cover with padded foam, secure with Kerlix and tape twice a day." Interview on 08/10/16 at 3:09 PM with the WCS revealed he was providing care for Resident #1 until February 2016, when he stopped coming to the facility, and resumed providing services for her on 06/28/16 when he began coming to the facility again. The WCS stated he was concerned about finding wounds without dressings in place, with the incorrect dressing being on the wound,	F 282	who have the potential were reviewed, skin audits completed and documented in Medical Record on 7/26/16. 3. Licensed Nurses were In serviced on 7/26/16 by the Director of Nursing regarding completing wound care treatments and dressing changes, as per physicians orders and documenting in the medical record. Facility Certified Nursing Assistants were In serviced on 7/26/16 by the Director of Nursing to notify the Licensed Nurse when a prescribed dressing was observed to be coming off or missing from a wound. All prescribed wound care, treatments, and dressing changes are completed, as per physicians orders. All wound dressings are observed 3x per week by the Director of Nursing or Wound Care Nurse and recorded on the Daily Wound Tracking Form to ensure that dressing changes were completed as per schedule and remain on the wounds. Wound Rounds are completed weekly to ensure compliance with wound care treatments and recorded QA Weekly Pressure Ulcer Record. 4. The results of the Quality Improvement monitoring will be reported by the Director of Nursing/ADON/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

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F 282	Continued From page 6	F 282		

with wound care not being provided as ordered and dressings not being changed as ordered. The WCS stated he documented any concerns on a discrepancy report that wasn't a part of the progress notes that go on the residents' medical record but was sent to the facility. The WCS stated he sent a discrepancy report on Resident #1 on 07/28/16 because he found no dressing on the left heel and the wound appeared not to have been treated as directed for several days and had dozens of maggots in the wound. When asked how maggots would have gotten in the wound on Resident #1's heel, the WCS stated a fly would have landed on the uncovered wound and laid eggs. The WCS stated there was no question that it had to have been left uncovered.

Interview on 08/11/16 at 11:08 AM with the current Director of Nursing (DON) revealed she became the DON on 07/27/16. The DON stated she first became aware of maggots being found in Resident #1's heel wound on 07/26/16 when the former DON gave her a copy of the WCS report. When asked in her clinical opinion how maggots got in Resident #1's wounds, she stated the only way she knew how maggots could have gotten in the wound would be for a fly to land on it and lay eggs. The DON was unable to say if Resident #1's heel wound had been left uncovered or not. The DON stated there were several instances of treatments not being documented as done but she didn't know if the treatments were done or not. The DON stated she had not questioned any of the nurses, who had failed to document that treatments were done, to determine if the treatments were not done.

Interview on 08/11/16 at 12:20 PM with Nurse #3

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F 282	Continued From page 7	F 282		

revealed she was familiar with Resident #1 and had provided wound care for her. Nurse #3 stated she had found Resident #1 without a dressing on her left heel and had also found dressings that hadn't been changed as ordered. Nurse #3 stated she had discussed her concerns with the former DON.

Interview on 08/11/16 at 5:43 PM with Wound Clinic staff revealed Resident #1 arrived for treatment on several occasions with the dressing still on the wound that was placed there on the previous visit. Wound Clinic staff stated she had called the former DON on several occasions and expressed concerns about the wound care that was not being provided by the facility including dressings not being changed daily as ordered and pressure relieving devices not being in place.

Interview with the transportation aide (TA) on 08/12/16 at 12:47 PM revealed he recalled transporting Resident #1 to the Wound Clinic when there was no dressing on the heel or it was soiled.

Interview on 08/12/16 at 1:17 PM with Resident #1's facility physician revealed he was notified the following day after the maggots were discovered in Resident #1's wound. When asked how the maggots could have gotten in the wound, he stated a fly would have landed on the uncovered wound and laid eggs in it.

A second interview on 08/12/16 at 2:28 PM with the DON revealed she expected wound treatments to be done every time they were ordered. The DON stated she expected dressings that were soiled, loose or missing to be replaced as soon as possible.

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F 282	Continued From page 8 In an interview with the Administrator on 08/12/16 at 3:52 PM revealed he expected treatments including wound care and dressing changes to be completed as ordered by the physician or WCS.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, physician and staff, the facility failed to provide wound care treatment as ordered for a pressure ulcer for 1 of 4 residents sampled for pressure ulcers. (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/21/15 with diagnoses including: history of deep vein thrombosis in both lower extremities, chronic kidney disease stage 3 and coronary artery disease. The most recent assessment was a quarterly Minimum Data Set (MDS) dated 04/28/16 which indicated Resident #1's cognition was moderately	F 314	Treatments for Resident #1 were ordered daily prior to 7/26/16. Due to a significant change in wound status, treatments began twice per day on 7/26/16 after evaluation by wound care nurse and Wound Care PA-C. Wound care orders then changed to daily on 8/2/16 per Wound Care PA-C. These treatments were completed by the wound care nurse daily Monday through Friday with assessment and evaluation of current treatments of the wounds being completed with Wound Care PA-C being notified as needed. Dressing changes on Saturday and Sunday were performed by staff licensed nurses with nursing administration verifying visually that	9/5/16

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F 314	Continued From page 9 impaired and she had fluctuating inattention and disorganized thinking. The MDS indicated Resident #1 had no behavioral symptoms or rejection of care and was dependent on staff for bed mobility, transfer, dressing, toilet use, personal hygiene and bathing. Resident #1 was assessed as having 1 unstageable pressure ulcer that contained eschar and measured 3.0 X 3.0 centimeters (cm). The MDS indicated she had a pressure reducing device for bed, nutrition or hydration intervention, pressure ulcer care and application of dressings to feet. A Care Plan which was last updated on 07/26/16 addressed resident's pressure ulcers to her left heel and left lower posterior leg with the goals that the areas would heal or show signs of healing by the next review and she would be free from further pressure ulcers through the next review. Interventions included: treatment as ordered, float heels in bed, notify physician if no improvement or worse, monitor skin with care for any reddened, suspicious or open areas and inform nurse, pressure reduction mattress to bed and treatment as indicated by wound care. A physician order dated 04/29/16 read: "Float heels completely off mattress and chair. Paint left heel daily with betadine; let dry. Cover with foam that has window cut; do in double layer. Wrap in Kerlix." A Wound Clinic note dated 06/13/16 indicated the pressure ulcer measured 2.1 X 1.5 X 0.4 cm. Listed in the note under dressing change frequency were the following instructions: "Change dressing every day or as needed for excessive drainage." The word "every" was underlined several times. A WC note dated	F 314	wound care dressing were clean, dry, and intact and had been dated for the appropriate treatment date. Resident #1 has been discharged from the facility on 8/9/16. 2. All residents with wounds are at risk for this alleged deficit practice. Residents who have the potential were reviewed and treatment records audited for appropriate compliance to orders received by physician and audit completed 8/1/16. 3. Licensed nurses were In serviced on 7/26/16 by the Director of Nursing regarding providing wound care, treatments, and dressing changes, per physician orders, and documenting in the medical record, plus completing dressing changes when the dressings are visually soiled, loose, or missing. Facility Certified Nursing Assistants were In serviced on 7/26/16 by the Director of Nursing regarding reporting to the Licensed Nurse when a resident□s dressing is observed to be soiled, loose, or missing to ensure the dressing will be changed. All resident wounds are visualized 3 x per week by the Director of Nursing and/or the Wound Care Nurse and daily by the Licensed Nurse assigned to the residents with wounds, to ensure that current dressings are in place and any wounds with soiled, loose, or missing dressings receive a dressing change. A review of the Administration Compliance report is reviewed by ADMIN/DON Weekly to ensure that treatments are given. Wound Rounds are completed by the wound care	

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F 314	Continued From page 10 06/20/16 indicated the pressure ulcer measured 2.2 X 2.1 X 0.5 cm and had increased in size with surrounding tissue and the wound was duskier. The note read in part: "needs better offloading to protect this wound." A physician's order dated 06/28/16 from the WCS read: "Cleanse left heel with normal saline; MediHoney to wound bed. Cover with dry gauze, secure with Kerlix and tape every other day." Interview on 08/10/16 at 3:09 PM with the Wound Care Specialist (WCS) revealed he was providing care for Resident #1 until February 2016, when he stopped going to the facility, and resumed providing services to her on 06/28/16. The WCS stated he was concerned about finding wounds without dressings in place, with the incorrect dressing being on the wound, with wound care not being provided as ordered and dressings not being changed as ordered. The WCS stated he documented any concerns on a discrepancy report that wasn't a part of the progress notes that go on the residents' medical record but was sent to the facility in a separate report. The WCS stated he sent a discrepancy report on Resident #1 on 07/28/16 because he found no dressing on the left heel and the wound appeared not to have been treated as directed in several days. A call to the former wound care nurse, who left employment at the facility on 07/28/16, was not returned. Interview on 08/11/16 at 11:08 AM with the current Director of Nursing (DON) revealed she became the DON on 07/27/16. The DON stated there were several instances of treatments not being documented as done but she didn't know if	F 314	nurse to ensure that current dressings are in place and recorded on the Wound Tracking Form. 4. The results of the Quality Improvement monitoring will be reported by the Director of Nursing/ADON/Unit Manager to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	

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(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 314	Continued From page 11	F 314		

the treatments were done or not. The DON stated she had not questioned any of the nurses, who had failed to document that treatments were done, to determine if the treatments were not done.

Interview on 08/11/16 at 12:20 PM with Nurse #3 revealed she was familiar with Resident #1 and had provided wound care for her. Nurse #3 stated she had found Resident #1 without a dressing on her left heel and had also found dressings that hadn't been changed as ordered. Nurse #3 stated she had discussed her concerns with the former DON.

Interview on 08/11/16 at 2:34 PM with Nurse #2, who was no longer employed at the facility, revealed she recalled changing Resident #1's dressing once a day when she worked until the order was changed to twice a day. Nurse #2 stated she didn't recall finding the dressing not in place or not being changed as ordered.

Interview on 08/11/16 at 2:49 PM with a Nurse Aide (NA) who stated she was regularly assigned to provide care for Resident # 1 on the day shift revealed she didn't recall seeing the pressure ulcer on her heel uncovered. The NA stated there were times when the drainage soaked through the bandage and she would notify the nurse.

Interview on 08/11/16 at 5:43 PM with Wound Clinic staff revealed Resident #1 arrived for treatment on several occasions with the dressing still on the wound that was placed there on the previous visit. Wound Clinic staff stated she had called the former DON on several occasions and expressed concerns about the wound care that was not being provided by the facility including

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 08/12/2016

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dressings not being changed daily as ordered and pressure relieving devices not being in place.

Interview with the transportation aide (TA) on 08/12/16 at 12:47 PM revealed he recalled transporting Resident #1 to the Wound Clinic when there was no dressing on the heel or it was soiled.

A second interview on 08/12/16 at 2:28 PM with the DON revealed she expected wound treatments to be done every time they were ordered. The DON stated she expected dressings that were soiled, loose or missing to be replaced as soon as possible.

In an interview with the Administrator on 08/12/16 at 3:52 PM the Administrator stated he expected treatments including wound care and dressing changes to be completed as ordered by the physician or WCS.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0623	A. BUILDING: _____ B. WING _____	C 08/12/2016

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L 006	.2104(C) REQUIREMENTS FOR LICENSE RENEWAL/CHANGE 10A-13D.2104 (c) The facility shall notify the Licensure and Certification Section of the Division of Facility Services within one working day following the occurrence of: (1) change in administration; (2) change in the director of nursing; (3) change in facility mailing address or telephone number; (4) changes in magnitude or scope of services; or (5) emergencies or situations requiring relocation of patients to a temporary location away from the facility. This Rule is not met as evidenced by: Based on observations, record review and interview with staff the facility failed to notify the North Carolina Division of Health Service Regulation (NCDHSR) of a change in the facility's address within 1 working day of the change. The findings included: Observation on 08/10/16 at 9:40 AM of the North Carolina Department of Transportation street sign posted at the end of the road leading to the facility revealed the road was named Cloverdale Road. In an interview with the Administrator on 08/12/16 at 3:24 PM about the change in the facility's address, the Administrator stated the facility requested a change in the name of the street leading to the facility and the street name was changed approximately 2 weeks prior to the survey. When asked if the facility had notified NCDHSR, he stated he was sure the corporate	L 006	L006 1. Information was sent to Becky Wertz, Section Chief, Division of Health Service Regulation, Nursing Home Licensure and Certification Section, North Carolina Department of health and Human Services. Confirmation email from Becky Wertz on 8/17/16 confirming the address change in the licensure and federal computer systems. 2. Reviewed any recent changes to the facility for the past 6 months 3. Any change that results in (1) change in administration;(2) change in the director of nursing;(3) change in facility mailing address or telephone number;(4) changes in magnitude or scope of services; or (5) emergencies or situations requiring relocation of patients to a temporary location away from the facility will be given to the Administrator and reported within	9/5/16

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 006	Continued From page 1 office had taken care of making that notification of change. Review of documents provided by the Administrator revealed NCDHSR was notified of the change in address on 08/12/16.	L 006	one working day following the occurrence. 4. The results of the Quality Improvement monitoring will be reported by the Administrator to the Quality Assurance Performance Improvement Committee monthly for 3 months. The QAPI committee will recommend revisions as indicated to sustain substantial compliance.	