STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING ______ B. WING ______	C 10/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD EXT BOX 1750 KING, NC 27021

(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 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. This REQUIREMENT is not met as evidenced by: Based on interviews and record review it was determined that the facility did not provide appropriate reasons for discharge for 1 of 1 residents (#1) who received a 30 day discharge notice. Findings included: Resident #1 had diagnosis including diabetes	F 201	F-201 For Resident #1: the 30 day discharge notice was rescinded, the care plan has been updated, also the physician has been notified, and he is following behavioral issues as they arise.	11/23/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/23/2016

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 201	Continued From page 1 mellitus type II, major depressive disorder, Horner ' s syndrome and unspecified dementia with behavioral disturbance. He was prescribed a prophylactic dose of Bactrium on 3/1/16. Review of the minimum data set assessment completed 8/20/16 revealed that the resident was able to understand and was understood by others. The minimum data set assessment revealed that the resident scored 12 on the brief interview of mental status; which indicated that the resident was alert and oriented. The assessment indicated that Resident #1 had no behaviors. He required extensive assistance with all activities of daily living except eating. Nurses note 10/15/16 revealed that the resident was headed to the dining room when he approached another resident and asked her to move. The resident was attempting to move her wheelchair when Resident #1 grabbed the other resident by her hair and pulled her head into his lap leaving her wheelchair balanced on only the back 2 wheels. Resident #1 then began striking the female resident repeatedly in the face and head. The two residents were separated by nursing staff and assessed for injuries. Resident #1 was sent out to the hospital for psychiatric evaluation. Interview with a Licensed Nurse at 1:44 PM revealed that Resident #1 rolled his wheelchair toward the desk where a number of ladies in wheelchairs were gathered in front of the nurse ' s station. Resident #1 asked if he could get by in a nice voice. The other resident responded you certainly can and began to adjust her wheelchair. In the blink of an eye, Resident #1 grabbed the back of her head and it was in his lap and I could hear him pounding. She stated that they had to pry Resident #1 ' s hands away from the other residents head. The residents were separated	F 201	No other residents have been issued 30 day discharge notices at this time. To ensure that 30 day discharge notices are appropriately issued, the Administrator and Director of Nursing will be re-educated by the Regional Clinical Services Director on the process for completing a 30 day discharge notice. All 30 day discharge notices will be reviewed by the Regional Clinical Services Director, or designee, prior to there being issued for a period of six months. The administrator will provide a summary of any 30 day discharges notices issued to the QAPI Committee for their review and input. Completion Date: 11/23/2016	

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VILLAGE CARE OF KING	**440 INGRAM ROAD EXT BOX 1750** **KING, NC 27021**

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F 201	Continued From page 2 and evaluated for injuries. She stated that the female resident had mild bruising to the back of her neck and two discolored area. Resident #1 said he was fine, laughed and said that he snapped. The nurse reported the resident said; I had her head in my lap beating the ________ out of her. The nurse reported that she observed no odd behavior that day but that the resident has always been short tempered. She stated that he had not actually been violent in the past year. Interview with the Director of Nurses (DON) on 10/29/16 at 1:53 PM revealed that the resident is alert and oriented " somewhat. " She stated that Resident #1 had some short and long term memory problems. The DON stated that she received a telephone call two weeks ago informing her of the incident between two residents and she had them both sent out to the hospital. Resident #1 returned to the facility early the next morning around 1 or 2 am. He received a diagnosis of dehydration and a urinary tract infection at the hospital. The resident was moved to the other side of the building to avoid interaction with the female resident involved in the altercation. The DON stated that the resident received a discharge notice because he had been involved in 4-5 altercations. She reported that his last roommate started chanting and Resident #1 got up and punched him in the face several times. The DON reported this incident took place approximately a year and a half ago and was unprovoked. Interview with a nursing assistant at 2:38 PM revealed that she did not see the incident. But when she spoke to Resident #1 about the incident he laughed and thought it was funny. The nursing assistant stated that the resident did not seem sorry and said that she had it coming. She reported no noticeable change in his	F 201		

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F 201	Continued From page 3 behavior prior to the incident. The NA stated that Resident #1 told her the other resident started cussing at him and swung her arm back at him. During interview with Resident #1 at 2:55 PM he stated, " We got jammed up on the corner. She looked at me and sneered. I floor boarded it. I did grab her by the head and hit her three times. I should not have hit her. " The resident stated that he did not want to leave the facility. Interview with Resident # 1 ' s Power of Attorney (POA) at 3:06 PM revealed that he had been given a 30 day discharged notice because he hit another resident. She stated that the ombudsman was present when she talked to the administrator. The POA said that the resident did not want to leave the facility because it was the closest to her home with a VA contract and she would not be able to visit him as much if he was far away. Interview with the administrator via telephone on 10/29/16 revealed that he gave the resident ' s responsible party a discharge notice and information regarding appeal in the presence of the ombudsman. The administrator stated that the facility was unable to meet the resident ' s needs. Review of the resident ' s care plan revealed no goals or interventions related to aggressive behavior. Review of the discharge notice on 11/5/16 revealed that the discharge notice failed to list a specific site for discharge. Review of the nurse ' s notes November 15th through November 29th revealed no documentation regarding the notice of discharge transfer or the reasons for discharge. Review of physician ' s notes revealed no documentation regarding the Resident #1 posing a threat to other residents. Interview with the DON at 4:15 PM on 10/31/16	F 201		

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F 201	Continued From page 4 revealed that she contacted the Veteran ' s Administration (VA) after the incident and the VA suggested that the resident go to a secure facility. She stated that it had been about a year or a year and a half since his last altercation. She stated that the resident had been at the facility between 6-8 years. Interview with the Facility administrator at 4:20 PM on 10/31/16 revealed that the resident was being discharged because he hit someone and had done so in the past. He stated the facility was no longer able to meet the resident ' s needs. The administrator said that the VA staff suggested that the resident be sent to a secure facility. The administrator stated that he would rescind the discharge notice. Interview with the POA on 10/31/16 she stated that the resident was given a 30 day discharge notice. Per the Power of Attorney the discharge notice was dated 10/18/16. The date of transfer was listed as 11/18/2916. The reason for notice stated, It is necessary for your welfare. Your needs cannot be met at this facility. The discharge notice stated that the facility would transfer the resident to a secure facility. The POA stated that the discharge notice listed the Date of transfer as 11/18/2916.	F 201		