STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	**877 HILL EVERHART ROAD LEXINGTON, NC 27295**

(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 000	INITIAL COMMENTS An unannounced, onsite recertification survey, follow-up survey, and complaint investigation was conducted on off hours beginning at 6:15 pm on 2/26/18.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		3/21/18

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

Electronically Signed | 03/15/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 585	Continued From page 1	F 585		

facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 585	Continued From page 2 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, family interviews, and staff interviews the facility failed to record a grievance and failed to provide a written grievance summary for 1 of 1 resident reviewed for grievances (Resident #36). Findings include: Resident #36 was admitted on 1/11/17 with admission diagnoses which included: Diabetes, bipolar disorder, depression, anxiety, and chronic pain. Review of Resident #36's most recent Minimum Data Set (MDS) revealed a comprehensive annual assessment with an Assessment	F 585	The filing of this plan of correction does not constitute an admission that the deficiencies alleged, did in fact exist. This plan o f correction is filed as evidence of the facility's desire to comply with regulations and to provide high quality of care. The facility failed to record a grievance and failed to provide a written grievance summary for 1 of 1 resident. All staff were in-serviced on the right to file grievances, how to file a grievance and the location of grievance forms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 585	Continued From page 3 Reference Date (ARD) of 1/27/18. The resident was coded as having been cognitively intact. The resident was coded as having had no hallucinations or delusions and did not display any abnormal behavior. Review of Resident #36's electronic medical record (EMR) revealed a progress note dated 2/11/18 and timed 2:40 PM. The note was written by the Administrator and read in part, a family meeting was held on 2/11/18 with Resident #36, Resident #36's family, the Administrator, the Registered Nurse (RN) Supervisor, and the DON. The resident's family expressed dissatisfaction in regards to an incident which had occurred on 1/14/18. The resident's family was requesting additional follow-up. Further review of Resident #36's EMR revealed a progress note dated 2/14/18 and timed 4:37 PM written by the Administrator. The note read the Administrator had spoken to the resident's family regarding the outcome of the investigation regarding the issues brought up in the family meeting which had taken place on 2/11/18 and both daughters had voiced understanding. Review of the facility grievances revealed no recorded grievances in February, 2018. Further review of the grievances revealed no recorded grievances from any residents or family members in January, 2018, December, 2018, November, 2018, October, 2017, July, 2017, June, 2017, May, 2017, and April, 2017. In addition there was only one grievance recorded per month for the months of March, 2017, May, 2017, August, 2017, and September, 2017 for a total of 4 recorded grievances in a 12 month period. None of the recorded grievances were from Resident	F 585	Residents will be reeducated on the right to file grievances, how to file a grievance and the location of grievance forms at the next scheduled resident council meeting on 03/13/18. All letter will be sent to all responsible parties from the Center Executive Director on the right to file grievances, how to file a grievance and the location of grievance forms at the facility. The interdisciplinary team will monitor all grievances daily in morning meeting to ensure proper policy and procedure and regulatory compliance. Copies of the grievance log will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) monthly for three months, to ensure proper compliance and reassess the need for ongoing monitoring. The Center Executive Director has been in contact with the QIO and will be on sight for a facility visit on 03/16/18, to assist the facility with providing the highest level of quality care possible. The person responsible for this plan of correction is the Center Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 585	Continued From page 4	F 585		

#36 nor her family.

During a meeting with a family member of Resident #36 on 2/27/18 at 11:55 AM she stated she had discussed a grievance with the Administrator and the Director of Nursing (DON) on 2/11/18. The family member further stated the Administrator called her the following day and informed her he had found the grievance to be unsubstantiated. The family member stated she had received no written communication from the facility regarding the result of the investigation from her grievance.

An interview was conducted with the DON on 3/1/18 at 4:16 PM. The DON stated she had met with Resident #36's family on 2/11/18 and the resident's family had expressed concerns regarding their mother and her allegations. The DON stated the families concerns were addressed with the investigation. The DON stated a Grievance/Concern form was not initiated. The DON stated it was her expectation for grievances/concerns to be documented on the Grievance/Concern form and followed through upon as part of the grievance process, which includes providing a copy of the Grievance/Concern Form to the resident/resident representative upon resolution of the grievance/concern.

An interview was conducted with the Administrator on 3/1/18 at 4:43 PM. The Administrator stated it was his expectation for grievances/concerns to be documented on the Grievance/Concern form and followed through upon as part of the grievance process, which includes providing a copy of the Grievance/Concern Form to the resident/resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 585	Continued From page 5 representative upon resolution of the grievance/concern.	F 585		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the	F 732		3/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 732	Continued From page 6 posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on review of the daily nurse staffing forms, observations and staff interviews, the facility failed to accurately report care hours provided by licensed and unlicensed personnel for 57 out of 57 daily nurse staffing forms reviewed. Findings included: The daily nurse staffing form was observed posted upon entrance to the facility on 2/26/2018 at 6:30 PM. The total number of hours provided by licensed and unlicensed staff exceeded the number of staff posted. Daily nurse staffing forms from January 1, 2018 through February 26, 2018 were reviewed and revealed the staffing hours calculated exceeded the number of licensed and unlicensed staff posted. The Billing Manager was interviewed on 2/28/2018 at 3:57 PM. She reported the scheduler was out sick, but she printed the daily nursing posting. She reported the report was auto-generated from the electronic schedule and the hours were calculated from the schedule. She added that she only checked the number of staff listed on the daily nurse staffing form, but had not checked the total hours. The Scheduler was interviewed on 3/1/2018 at 9:35 AM. She demonstrated entering the information into the schedule and printed out the	F 732	The facility failed to post accurate number of care hours provided by licensed and unlicensed personnel. The scheduler and scheduling assistant were in-serviced by the Center Executive Director on ensuring schedules for licensed and unlicensed staff are put into the scheduling system to appropriately reflect the accurate number of care hours daily. All licensed nurses were in-serviced by the Nurse Practice Educator on checking the daily posting of nurse staffing form, each shift, to ensure proper census and staff hours are correct, and to ensure regulatory compliance. Daily staffing form from prior day will be reviewed daily to ensure accurate care hours were posted for licensed and unlicensed staff to ensure regulatory compliance. Copies of the daily nurse staffing forms will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) monthly for three months, to ensure proper compliance and will reassess the need for ongoing monitoring. The Center Executive Director has been in contact with the QIO and will be on sight for a facility visit on 03/16/18, to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 732	Continued From page 7 daily nurse staffing form. Licensed and unlicensed staff scheduled for 12 hour shifts starting at 7:00 AM were calculated into the total hours twice, with 12 hours on 1st shift and 12 hours on 2nd shift. Licensed and unlicensed staff scheduled for 12 hour shifts starting at 7:00 PM were calculated twice, 12 hours on 2nd shift and 12 hours on 3rd shift. The Scheduler reported she checked the number of staff on the electronic daily staffing form, but had not checked the total hours. She concluded by reporting she felt she entered the schedule information incorrectly and there was a corporate consultant who could give her direction with using the schedule to generate a correct daily staffing form. The Administrator was interviewed on 3/1/2018 at 9:51 AM and he reported it was his expectation that the daily staffing form would reflect the true hours of care provided by staff each shift.	F 732	assist the facility with providing the highest level of quality care possible. The person responsible for this plan of correction is the Center Executive Director.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		3/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 812	Continued From page 8 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to clean food service equipment and maintain intact food contact surfaces. The facility failed to maintain clean handles on four of four handles on a four door reach in cooler observed for cleanliness. The facility failed to provide plate covers with an intact interior surface on 27 of 36 plate covers stored on drying rack and 10 of 15 plate covers covering resident food on a tray cart. Findings Included: 1. An observation of the kitchen conducted on 2/26/18 at 6:27 PM revealed the following: a. Four of four handles on the reach in cooler were observed to have a buildup of dried debris on the interior aspect of each handle. b. Twenty-seven of thirty-six plate covers which were stored on a drying rack were observed to have had an impaired integrity surface. The material from which the cover was made was observed to be flaking off on the interior side, or food contact side, of the plate covers. 2. An observation of the kitchen conducted on 2/28/18 at 11:46 AM revealed the following: a. Four of four handles on the reach in cooler were observed to have a buildup of dried debris on the interior aspect of each handle. b. Ten of fifteen plate covers which were on resident food trays on a cart which was to be delivered to the 100 hall were observed to have an impaired integrity surface, where the material from which the cover was made was observed to	F 812	The facility failed to clean food service equipment and maintain intact food contact surfaces. The director of Dining Services (DDS) thoroughly cleaned the four handles on the reach in cooler on the evening of 03/01/18. The Director of Dining Services revised the cleaning schedule to include the cooler handles as part of daily cleaning tasks. The Director of Dining Services completed an in-service with the cooks and dietary aides regarding the revised daily cleaning schedule to now include the four handles on the reach in cooler. The Director of Dining Services has began discarding the plate covers that had an impaired integrity surface. An order was placed on 03/07/18 and 03/09/18 to Aladdin Temp Rite to replace all plate covers that had an impaired integrity surface. The Director of Dining Services will complete daily checks of the cleaning schedule to ensure proper regulatory compliance for four weeks, then weekly for 2 months. The Director of Dining Services and the Registered Dietician will do weekly audits times 4 weeks, the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 812	Continued From page 9 flaking off on the interior side, or food contact side, of the plate covers. An interview and observation that was conducted with the Dietary Manager on 2/28/18 at 12:19 PM revealed the 100 hall meal tray cart was ready to be delivered to residents. Observation of the ten of the fifteen plate covers revealed the interior surface of the plate covers had become impaired to the point it could be easily scratched off or fall off and get into the resident foods. The Dietary Manager stated it was her expectation for the food contact surfaces such as the interior surface of the plate covers be intact so pieces of the cover could not drop onto resident's food. In addition the Dietary Manager stated it was her expectation for the handles or hand contact surfaces of the four door reach in cooler and other food service equipment to be clean. During an interview conducted on 3/1/18 at 4:35 PM the Administrator stated it was his expectation for handles and hand contact surfaces on food service equipment to be kept clean. In addition the Administrator stated it was his expectation for plate covers to be intact without the potential for pieces of the cover being able to drop onto resident's food.	F 812	weekly for 2 months, to ensure plate covers do not have impaired integrity surfaces. A report of the cleaning schedule and audits of the plate covers will be submitted to the Quality Assurance Committee (QAPI) to ensure proper compliance and will reassess the need for ongoing monitoring. The Center Executive Director has been in contact with the QIO and will be on sight for a facility visit on 03/16/18, to assist the facility with providing the highest level of quality care possible. The person responsible for this plan of correction is the Center Executive Director.	
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F 865		3/21/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 865	Continued From page 10 §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitoring of interventions that the committee put into place following their 1/26/17 recertification survey. The area of deficient practice was Food Procurement, Storage, Preparation, and Serve and was cited again on the current recertification survey on 3/1/18. The failure of the facility to maintain sufficient Food Procurement, Storage, Preparation, and Serve on two consecutive surveys of record revealed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: 483.60- Based on observation and staff interview the facility failed to allow dishware to air dry; failed to ensure dishware was free from food particles; ensure food was labeled and dated; and ensure the shelving and walls in the walk-in cooler, the hood vents, and the convection oven were clean during their recertification survey on 1/26/17 resulting in a deficiency in Food Procurement,	F 865	The repeat deficiency was in the area of Food Procurement, Storage, Preparation and Serve (F812). The Center Executive Director completed a re-education with the facility Quality Assurance Performance Improvement Committee, related to the facility process and intent of the Quality Assurance Performance Improvement (QAPI), which included the responsibilities the QAPI committee to ensure sustainability with identified areas of opportunity, with members of the QAPI committee. The facility met with the facility Medical Director, to review the current survey outcomes and reviewed preliminary plan of correction for this survey. The Center Executive Director and/or Clinical Quality Specialist (Regional Nurse) will review weekly times 4 weeks, the audits for deficiencies to ensure compliance with intended regulations. Then monthly time three months to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 865	Continued From page 11 Storage, Preparation, and Serve. 483.60- Based on observation and staff interview the facility failed to maintain contact surface of the plate covers and failed to maintain clean hand contact surface on the handles of the reach-in cooler during the current recertification survey on 3/1/18 resulting in a deficiency in the Food Procurement, Storage, Preparation and Serve. An interview with the Administrator and the Director of Nursing on 3/1/18 at 4:57 pm revealed the facility had their QAA meetings monthly. The Administrator, Director of Nursing, Department Heads, Medical Director, a Nurse, and a NA attended the monthly meetings and the Pharmacist attended quarterly. The Administrator stated they had recently began a daily stand up and stand down meeting to ensure that all QAA issues were being follow up on. He stated they would continue to monitor the issues found in the kitchen in their QAA process and his expectation was that they would have no further Dietary issues.	F 865	ensure proper compliance. The Center Executive Director has been in contact with the QIO and will be on sight for a facility visit on 03/16/18, to assist the facility with providing the highest level of quality care possible. The person responsible for this plan of correction is the Center Executive Director.	