STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to have a comprehensive emergency preparedness(EP) plan. The EP manual failed to include emergency prep testing and conduct any staff exercise to test their EP plan before 11/28/17. The EP manual failed include the policy and procedures for sheltered residents and staff who remained in the facility, policy and procedures to track resident and staff who were moved to other facilities and policy and procedures for staff, residents and others who	E 001	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers	8/23/18

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

Electronically Signed | 08/17/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 1 remained in the facility during and emergency. The EP communication plan failed to include contact information of staff, pharmacy, resident (need comma) physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman. The EP communication plan failed to include procedures of sharing information and medical documentation of it resident with other health care providers that would be providing continuity of care and method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency. The EP communication plan failed to establish a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. Findings included: 1. A. Review of the EP Manual revealed the facility had not conducted the initial discussion or any exercises with staff to test their EP plan. B. Review of the EP manual provided by the facility revealed no plan or procedure in place to track residents and staff on duty who remained in the facility during emergencies. The manual did not include any tracking system for resident and staff who left facility and were sheltered by other facilities. C. Review of the EP manual provided by the facility revealed the facility did not establish a criteria for its resident or staff who will be sheltered in the facility in case of emergency. The facility did not include a procedure for sheltering its staff, residents and others who remained in the facility in an event when evacuation could not be	E 001	allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency cited: E001 The facility Emergency Preparedness manual failed to include: 1) Emergency prep testing and conduct any staff exercise to test their EP plan before 11/18/17 2) Policies and procedures for sheltered residents and staff who remained in the facility 3) Policies and procedures to track resident and staff who were moved to other facilities 4) Contact information of staff, pharmacy, resident physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman 5) Procedures of sharing information and medical documentation of a resident with other health care providers that would be providing continuity of care 6) Method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency 7) Establishing a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives 2. The procedure for implementing the acceptable plan of correction for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 2 executed. D. Review of the EP manual provided by the facility revealed the communication plan did not include the names and contact information of all staff working in the facility, the names and contact information of resident ' s physicians, pharmacy services and contact information of other facilities including but not limited to its sister facilities that would be providing services and care to the resident during and emergency. E. Review of the EP manual provided by the facility revealed the communication plan did not include contact information of the North Caroling Nursing Home Licensure and Certification Agency and contact information of Long Term Care Ombudsman. F. Review of the EP manual provided by the facility revealed the communication plan did not include process and procedure as to how the facility would communicate and share information of its occupancy, residents needs and the facility ' s ability to provide assistance to authorities having jurisdiction or "the Incident Command Center" during an emergency situation. G. Review of the Communication Plan in the EP manual provided by the facility revealed no documentation as to how the facility ' s emergency plan would be shared with its residents, family members and/or resident representatives. During an interview on 7/26/18 at 2:07 PM, the Administrator reviewed the emergency preparedness manual and confirmed the initial comprehensive training had not been done before 11/28/17. The Administrator also acknowledge	E 001	specific deficiency cited: E-001 The facility Emergency Preparedness manual will be updated to include: Emergency prep testing and conduct any staff exercise to test their EP plan; Policies and procedures for sheltered residents and staff who remained in the facility; Policies and procedures to track resident and staff who were moved to other facilities; Contact information of staff, pharmacy, resident physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman; Procedures of sharing information and medical documentation of a resident with other health care providers that would be providing continuity of care; Method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency; Establishing a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: E001 A review of the Emergency Preparedness manual will be conducted by Regional Nurse Consultant for compliance of Emergency prep testing and conduct any staff exercise to test their EP plan; Policies and procedures for sheltered residents and staff who remained in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 3 the identified areas were missing and/or had not been addressed and the manual would be revised. Administrator indicated he was responsible for the completion of the EP.	E 001	facility; Policies and procedures to track resident and staff who were moved to other facilities; Contact information of staff, pharmacy, resident physicians, contact information of the State Licensing and Certification Agency and State Long Term Care Ombudsman; Procedures of sharing information and medical documentation of a resident with other health care providers that would be providing continuity of care; Method of sharing information regarding facility needs and its ability to provide assistance for its occupancy to authorities having jurisdiction during an emergency; Establishing a procedure of sharing information and providing documents from its emergency plan to residents, family members or resident representatives by completion date 8/23/2018 and Biannually X 2. Findings will be reviewed at Quarterly Quality Assurance and Improvement Committee X 1 for further problem resolution if needed. 4. The title of the person responsible for implementing the acceptable plan of correction: E-001 Administrator 5. Date when corrective action will be completed: E-001 August 23, 2018	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take	F 565		8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 565	Continued From page 4 reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident interviews and staff interviews, the facility failed to resolve grievances that were reported in resident council meetings for 5 of 5 consecutive months for 2 of 3 residents (Resident #54 and #62) who participated in the resident council meeting.	F 565	1. The plan should address the processes that lead to the deficiency cited: F565 Facility failed to resolve grievances that were reported in resident council meetings for 5 or 5 consecutive months for resident #54 and #62, who participated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 565	Continued From page 5 Findings included: Review of the minutes from the previous five monthly resident council meetings from March 2018 to July 2018 revealed the following: Review of the resident council meeting minutes dated 3/12/18, documented concern of short staffed on weekends and trays were not being passed out at breakfast on identified hall and in the dining room. Resident council minutes dated 4/16/18, documented nurse aide short staffed on the weekends and not enough help on the halls, trays for all meals not being passed out in a timely manner and the food was cold. Resident council minutes dated 5/23/18, documented the Director of Nursing was informed of the short staffing on the weekend, trays were not being passed out in the dining room and assigned staff not showing up in the dining room and evening trays sitting on halls 10-15 minutes. DON informed the resident new staff were being hired. Resident council minutes dated 6/11/18, documented trays were not being passed out in a timely manner and nurse aides shortage on weekends and aides calling out. Resident council minutes dated 7/16/18, documented shortage of staff on the weekends on all units, trays were taking 15-20 minutes to receive trays in the dining room for breakfast and occasional lunch and dinner. During an observation on 7/22/18 at 6:00 AM to	F 565	in the resident council meeting. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: F565: Administrator and Activity Director educated by Regional Nurse Consultant August 1, 2018 on Policy number 601 Meetings Section 7 Review Administrative Resolutions and discuss those resolved from last meeting, Section 8 Provide the Administrator the original minutes of the meeting along with the Administrator Response to Resident Council form for signature, Section 11 During the subsequent Activities Director□s weekly meeting with the Administrator, validate completion of Administrative Response to Resident Council form with Administrator□s signature. During Resident council meeting August 14, 2018, residents were educated on grievance process and location of forms. Previous grievances were resolved. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: The Regional Nurse consultant will audit the Resident Council minutes, and review the Administrator Response to Resident Council form and Resident Council minutes for grievance resolution and written response to resident council group monthly X 3. Activities Director will educate residents during monthly meetings on the grievance process and location of the forms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 565	Continued From page 6 9:30 AM, 4 residents were in the dining room waiting for breakfast. Review of the meal tray delivery schedule for the dining room revealed the breakfast meal was scheduled to be served at was 7:15 AM. The staff did not arrive to the dining room to begin serving resident breakfast meals until 8:30 AM. During the resident council meeting on 7/25/18 at 10:00 AM 3 of 3 residents were identified as alert and oriented. The activities staff was present per resident request. The residents revealed an issue with the resolution of group grievances. Two residents in the 7/25/18 at 10:00 AM resident council meeting reported not all grievances were acted upon promptly by the facility and there was no reasonable or satisfiable resolution for the group. The residents reported the on-going group concern included shortage of staff on the weekends and not being able to eat breakfast in the dining room on the weekend due to staff shortage and not being informed of the grievance process. During the resident group meeting Resident #54, who was identified as alert and oriented, stated the meals arrived late and residents were unable to eat in the dining room on the weekends due to shortage of staff and staff call outs. Resident #54 reported residents had been told a few times the dining room was closed due to no staff. Resident #54 indicated residents should have the right to eat in the dining room. Resident #54 stated this concern had been shared with administrator who had done nothing to correct the problem. Resident #54 added that she was unaware of the grievance process or how to complete the grievance form, so she would report her concerns	F 565	The Audits will be presented during the Quarterly Quality Assurance meeting X 1 for further problem resolution if needed. 4. Title of the person responsible for implementing the acceptable plan of correction: Regional Nurse Consultant 5. Date when corrective action will be completed: August 23, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 565	Continued From page 7	F 565		

to the staff. Resident #54 indicated a written respond to group grievance had not been provided to the group.

During the group meeting Resident #62 confirmed the concern that meals were delivered late and residents were unable to eat in the dining room on the weekends. Resident #62 stated her preference was to eat in the dining room on the weekends like she did during the week, but due to staff shortage residents were asked to eat in their room. Resident #62 further stated she was unaware of the grievance process and location of the forms, but she had spoken with staff about her concern to eat in the dining room on weekends.

During an interview on 7/25/18 at 10:00 AM, the Activities Director and Activities Assistant both stated that when residents in group report concerns the concerns were given to the department head for a response, but a response to the action taken was not always provided. Both staff indicated they had not reviewed the grievance process and/or resident rights in group because they had been informed the resident rights/grievances were done with residents upon admission.

During an interview on 7/25/18 at 1:51 PM, the Director of Nursing (DON) indicated that when she received the group grievance for May regarding weekend staffing, meals being delivered late, cold, foods etc., she spoke with the group and wrote a statement on the grievance form about what she was going to do, but she had not followed up with the group regarding the action that had taken place. The DON stated she had not provided written statements to residents in response to grievances. DON stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 565	Continued From page 8 weekend supervisor was expected to provide coverage in the dining room on the weekends and if there was a call out another person should be assigned. During an interview on7/25/18 2:09 PM, the Administrator and Director of Nursing stated that he had attended several of the resident council meetings and had addressed all the concerns of the resident group. He stated he did not provide residents with written resolutions to the concerns whether it was group or individuals. He stated the expectation was for the department head to respond to resident grievances within 3 to 5 days or sooner if needed and group prior to the next meeting. He further stated he was uncertain whether the staffing monitoring tool the DON put in place was working or effective for the weekends. The DON indicated each assignment sheet should have a staff assigned to the dining area and if there was a call out the unit managers should provide a replacement. She added she had not been checking or monitoring to see if the system was effective or not. She was unable to provide information on the monitoring that was done for resident meal trays being served late.	F 565		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to code the discharge Minimum Data Set (MDS) assessment to reflect accurately the discharge status for 1 of 8 residents, reviewed for	F 641	1. The plan should address the processes that lead to the deficiency cited: F641: Facility failed to code the MDS assessment accurate in the areas of	8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 641	Continued From page 9 assessment accuracy (Resident #164). Findings included: Resident #164 was admitted to the facility on 5/10/18 with diagnoses included sepsis, colostomy (artificial opening for bowel) and cerebral infraction. Record review of the nurses ' notes, dated 5/30/18, revealed discharge planning progress note, indicated that Resident #164 to discharge home with family support on 5/31/18. Record review of the Discharge MDS assessment, dated 5/31/18, revealed Resident #164 was discharged to acute hospital. Record review revealed Resident 164 ' s Discharge Summary, dated 5/31/18, indicated that the resident admitted for skilled nursing service, therapy and discharged home. The document signed by physician. Record review revealed Resident 164 ' s Transfer/Discharge Report, dated 5/31/18, indicated that Resident #164 discharged to private home/apartment with family. On 7/25/18 at 10:50 AM, during an interview, Nurse #7 indicted that she was responsible for MDS assessment of Resident # 164. The resident went home with his wife on 5/31/18. The nurse stated that she put incorrect discharge coding for discharge MDS assessment on 5/31/18 for Resident #164. On 7/25/18 at 10:55 AM, during an interview, the Director of Nursing indicated that her expectation	F 641	discharge status of 1 of 3 samples who were reviewed for discharge planning. The resident was discharged to home. The MDSC inadvertently coded Question A2100 Discharge Status incorrectly on resident #164_ 5/31/18 DC RNA MDS as discharge to the hospital. On 07/25/18, the MDSC modified resident #164□s 5/31/18 Discharge (DCRNA) MDS to code Question A2100 Discharge Status to Community and not to Acute Hospital. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: F641: MDS Coordinator and/or MDSC Consultant will conduct an audit of all discharged residents discharged as Discharged Return Not Anticipated within the last 30 days to ensure Question A2100 Discharge Status was correctly coded. The audit will be completed by date of compliance date 8/23/18 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: On 8/1/18, the MDSC Consultant provided education to the MDSC regarding the RAI Rules for coding Question A2100 Discharge Status. The MDS Consultant or designee will audit 5 discharged residents□ Discharge Return Not Anticipated MDS to ensure Question A2100 Discharge Status was coded correctly. This will be accomplished one time a week for 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 641	Continued From page 10 the MDS nurses to provide accurate coding, reflecting actual resident ' s status.	F 641	month, twice a month for 1 month and monthly for one month. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDS. The Audits will be presented during the Quality Assurance meeting X 1 for further problem resolution if needed. 4. Title of the person responsible for implementing the acceptable plan of correction: Steve Ventura RN Data Analysis Verification Specialist 5. Date when corrective action will be completed: August 23, 2018	
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	F 732		8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 11 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 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 observation and staff interviews, the facility failed to post the nurse staffing information in an area visible within the facility to residents and visitors for five (5) of the 5 days of the survey period. Findings included: On 7/22/18 during facility initial tour and multiple observations throughout the day including at 6:45 AM and at 12:50 PM, revealed no nurse staffing information was observed posted in an area clearly visible to residents and visitor. Multiple observations made on 7/23/18 at 8:30 AM and at 2:15 PM, 7/24/18 at 9:00 AM and at 1 :35 PM, 7/25/18 at 8:00 AM and at 10: 00 AM and on 7/26/18 at 10:03 AM and at 3:00 PM revealed no staffing information was observed posted at the entrance or in an area clearly visible to	F 732	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to post the nurse staffing information in an area visible within the facility to residents and visitors 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: Nurse Staffing Posting was relocated to front lobby at eye level in a location accessible to all visitors and residents on 07/26/2018 3. The monitoring procedure to ensure that the plan of correction is effective and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 12 residents and visitors within the facility. During an interview on 07/26/18 on 03:40 PM, the Director of Nursing (DON) revealed that the facility used daily staffing sheets and the information was posted on her office door only. In an observation the DON and surveyor walked to DON's office to review the sheet posted on her office door. The daily staffing sheets included the facility census and a breakdown of nurses and nurse assistants scheduled per shift. The sheet also indicated it should be posted in a clearly visible area for residents and visitors. The sheet was not visible to the resident and their visitors when the office door was open. The Director of Nursing verbalized that she was responsible for completing the daily nurse staffing sheet and she was unaware the information should be posted in any other location (visible location). During an interview on 07/26/18 on 06:12 PM, the Administrator indicated it was his expectation the daily staffing sheets were updated to include daily nursing staff schedules per shift and posted daily in an area clearly visible to their residents and visitors.	F 732	that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Administrator and/or DON will conduct audits for daily posted staffing in a location accessible to all visitors and residents weekly x 4 weeks; biweekly x 1 month and then monthly x 1. 4. The Title of person responsible for implementing the acceptable plan of correction: Director of Nursing 5. Date of Completion: August 23, 2018	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 13 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove one expired Novolog insulin pen from 1 of 2 medication carts on Teal hall, one box of expired Ipratropium Bromide, one expired plastic container of Calcium with Vitamin D and one box of expired Senior Tabs Multivitamins from the medication storage room on Teal hall, failed to provide the date of opening for one of multi vial Lantus insulin medication. Findings Included: 1. a. On 7/22/18 at 10:10 AM, during the observation of the medication cart on Teal South hall with Nurse #2, there was one expired Novolog Flex Pen (insulin injector), opened on 6/21/18. On 7/22/18 at 10:10 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible to check expired medications. The nurse confirmed	F 761	1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to remove one expired Novolog insulin pen from medication cart, one box of expired Ipratropium Bromide, one expired plastic container of Calcium with Vitamin D and one box of expired Senior tabs Multivitamins from the medication storage room on Teal hall, and failed to provide the date of opening for multi vial lantus insulin medication. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All expired medication and insulin pen without date removed from service on 7/23/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 14 that she had not checked the expiration date on Novolog Flex Pen in her medication administration cart at the beginning of her shift. b. On 7/22/18 at 10:15 AM, during the observation of the medication cart on Teal South hall with Nurse #2, there was one multi vial of Lantus insulin, 100 units in 1 ml (milliliter) with no date of opening. On 7/22/18 at 10:15 AM, during an interview, Nurse #2 indicated that all the nurses, who worked on the medication carts, were responsible to put the date of opening on multi vial insulin. 2. On 7/22/18 at 10:45 AM, during the observation of the medication storage room on Teal hall with Nurse #1, there were expired medications found: one box of Ipratropium Bromide, 30x3 ml plastic vials, expired in May 2018, one plastic container of Calcium 600 mg (milligram) with Vitamin D, expired in May 2018, and one box of Senior Tabs Multivitamins, expired in June 2018. On 7/22/18 at 10:45 AM, during an interview, Nurse #1 indicated that medication room supplier checked the expiration date while restocking the medication storage rooms. She expected all the nurses should check the expiration date and put the date of opening on medications in the storage room and medication carts. On 7/19/17 at 10:00 AM, during an interview, the Assistant of Director of Nursing indicated that all the nurses were responsible to check all the medications. Her expectation was that no expired items be left in the medication carts or in medication storage rooms.	F 761	Drugs and biologicals in each applicable storage area and medication carts will be audited and any expired items or improperly stored items will be removed and disposed of per facility policy. Nurses will be in-serviced on storage and expiration of medications by DON and/or ADON using Omnicare Recommended Minimum Medication Storage Parameters 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Director of Nursing, RN Unit manager or Unit Coordinator, House Supervisor or Assistant Director of Nursing will conduct audit of all medications on each medication cart and medication storage room weekly X 4 weeks, Bi Weekly X 2 weeks and monthly X 1. Results of audits will be reviewed at Quarterly Quality Assurance meeting X 1for further problem resolution if needed. All new hire licensed nurses will be educated in general orientation on storage and expiration of medications using Omnicare Recommended Minimum Medication Storage Parameters 4. The Title of person responsible for implementing the acceptable plan of correction: Director of Nursing 5. Date of Completion: August 23, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 SS=E	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. §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 label and date foods in one of one walk-in refrigerator and one of one walk-in freezer and to discard expired foods in one of one walk-in refrigerator and the kitchen ' s dry storage area. Findings included: 1a. An observation of the walk-in refrigerator on 07/22/18 at 6:35 a.m. revealed two commercial containers of "Chicken Salad Supreme." One container was labeled as opened on 07/14/18 with an expired use-by date of 07/20/18. The other container less than half full was not labeled by staff with a date of opening or a use-by date.	F 812	1. The plan of correcting the specific deficiency. The plan should address the process that lead to the deficiency cited: F812 The facility failed to label and date foods in one of one walk-in refrigerator and one of one walk in freezer and to discard expired foods in one of one walk-in refrigerator and the kitchen□s dry storage area. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: F812 On 7/22/18, two commercial containers of Chicken Salad Supreme, a clear plastic container of pineapple rings, two	8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 16 b. An observation of the walk-in refrigerator on 07/22/18 at 6:35 a.m. revealed a clear plastic container of pineapple rings labeled with a prepared date of 07/15/18 and an expired use-by date of 07/21/18. c. An observation of the walk-in refrigerator on 07/22/18 at 6:35 a.m. revealed two sandwiches each wrapped in waxed paper and unlabeled with a name, date prepared or use-by date. d. An observation of the walk-in freezer on 07/22/18 at 6:45 a.m. revealed two frozen commercially made pies wrapped in cellophane. One was unlabeled with a name or use-by date. The other labeled as "lemon cream pie" was not labeled with a use-by date. e. An observation of dry storage on 07/22/18 at 6:55 a.m. revealed a commercial container of poultry seasoning labeled with an opened date of 06/20/16 and an expired use-by date of 06/20/18. In an interview on 07/22/18 at 7:00 a.m., Cook #1 indicated that expired items were generally discarded throughout each day as ingredients for meal preparation were gathered from the refrigerator, freezer or dry storage. She stated that the frozen pies were separated from the box received from the vendor. Sandwiches were prepared for lunch in advance and they should be labeled and dated, as well as any left-over food, before storing. In an interview on 07/22/18 at 10:50 a.m., the Dietary Manager stated that items were labeled and expired items discarded on a daily basis. She indicated that the cooks and cook helpers shared responsibility for these tasks. If a commercial box	F 812	sandwiches and two frozen pies found expired in walk in cooler were immediately removed and discarded at the time of observation. On 7/22/18, a commercial container of poultry seasoning found expired in dry storage was immediately removed and discarded at the time of observation. All Dining Services employees were in-serviced regarding proper procedures for discarding expired food items, labeling and dating items when received (7/23/18) 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: F812 A sanitation inspection will be conducted by Corporate Registered Dietician weekly x 4 weeks, twice-monthly x 4 weeks, and monthly X 1 to ensure compliance with corrective actions and sanitation standards. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. All new hires will receive in-service education by Dietary Services Manager on proper procedures for discarding expired food, labeling and dating items when received and opened. Findings from sanitation inspections will be reviewed at the Quarterly Quality Assurance meeting x1 for any further problem resolution if needed. 4. The title of the person responsible for implementing the acceptable plan of correction: F812	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 17 contained multiple items, the cooks and helpers labeled individual items when removed. A more thorough review of dated and expired items was done on Mondays and Thursday when food supplies are received from vendors. The shelves were reorganized to follow the "first in, first out" rule. She stated that she did a spot check at least once a week and used the opportunity to remind staff members of the food storage policy. She shared her expectation that food be appropriately labeled with name, date prepared or opened and a use-by date and that expired items be discarded. Dietary staff received monthly in-services; the topic of food storage was covered on 05/22/18.	F 812	Corporate Registered Dietician 5. Date when corrective action will be completed: F812 August 23, 2018	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in July of 2017. This was for a recited deficiency, which were originally cited on 7/19/17 during the recertification survey and on the current recertification survey. The repeated deficiency was in the area of Drug records, label/ store drugs and biologicals (F431 which is now F761). The continued failure of the facility during	F 867	F867 QAPI/QAA Improvement Activities-medication storage 1. The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to effectively maintain implemented procedures and effectively monitor the interventions that the committee put into place in July of 2017. This was for a recited deficiency, which	8/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 867	Continued From page 18 two federal surveys of record shows a pattern of the facility's inability to sustain an effective quality assurance Program. The Findings included: This tag is cross-referred to: 1.F-761: Based on observations and staff interviews the facility failed to remove one expired Novolog insulin pen from 1 of 2 medication carts on Teal hall, one box of expired Ipratropium Bromide, one expired plastic container of Calcium with Vitamin D and one box of expired Senior Tabs Multivitamins from the medication storage room on Teal hall, failed to provide the date of opening for one of multi vial Lantus insulin medication. The facility was cited during the 7/19/17 recertification survey for failure to remove two boxes of Ensure Clear expired medications from 1 of 2 medication carts on Mauve hall, one vial of expired Lantus insulin, expired Lantus insulin pen from 1 of 2 medication cart on Teal hall, one bottle of expired R-Dukes Magic Mouth Wash and expired plastic bag of 5% Dextrose from the refrigerator in the medication storage room on Mauve hall. During an interview on 07/26/18 at 6:12 PM, the Administrator indicated the Quality Assurance (QA) committee identifies areas of concern, does a root cause analysis, develops a plan, audits and monitors that plan and discusses the outcome. He indicated QAA committee meets quarterly and on as needed basis to discusses the identified concerns, goals met, and improvement needed. Regarding medication storage, Administrator	F 867	was originally cited on 07/19/2017 and facility failed to remove one expired Novolog insulin pen from medication cart, one box of expired Ipratropium Bromide, one expired plastic container of Calcium with Vitamin D and one box of expired Senior tabs Multivitamins from the medication storage room on Teal hall, and failed to provide the date of opening for multi vial lantus insulin medication. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited: All expired medication and insulin pen without date removed from service on 7/23/2018. Medications in each applicable storage area and medication carts will be audited and any expired items or improperly stored items will be removed and disposed of per facility policy. Nurses will be in-serviced on storage and expiration of medications by DON and/or ADON using Omnicare Recommended Minimum Medication Storage Parameters 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements: Director of Nursing, RN Unit manager or Unit Coordinator, House Supervisor or Assistant Director of Nursing will conduct audit of medictions on each medication cart and medication storage room monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON STREET BURLINGTON, NC 27217

(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 867	Continued From page 19 indicated the facility's consultant pharmacist conducts regular in-service for staff and monitors med pass. He further stated the consultant pharmacist also checks the medication carts and expired medication were brought to the Director of Nursing (DON) for further action. Administrator also stated DON has a monitoring tool in place. He stated it was his expectation the nurses and pharmacist check the medication carts and discard any expired drugs appropriately. During an interview on 07/26/18 at 6:24 PM, DON stated the nursing staff were observed during new hire orientation and during monthly random observation that were made on different shifts by unit managers. She stated an audit system was in place to decrease the medication administration error rate.	F 867	X 12 months. Results of audits will be reviewed at Quarterly Quality Assurance meeting X 4 for further problem resolution if needed. All new hire licensed nurses will be educated in general orientation on storage and expiration of medications using Omnicare Recommended Minimum Medication Storage Parameters 4. The Title of person responsible for implementing the acceptable plan of correction: Director of Nursing 5. Date of Completion: August 23, 2018	