PRINTED: 09/24/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED				
					С	
		345419	B. WING		08/17/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	ER		17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 000	INITIAL COMMENTS		F 00			
		ation survey was conducted h 08/17/18. Immediate ed at:				
	(J)	600 at a scope and severity				
	The tags F600 and F6 Quality of Care.	607 constituted Substandard				
		began on 07/30/18 and was . A partial extended survey				
F 600 SS=J		Neglect	F 60		8/18/18	
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to				
	§483.12(a) The facilit	y must-				
	physical abuse, corporation involuntary seclusion; This REQUIREMENT by: Based on record revi	is not met as evidenced iew, staff and family member		This allegation of compliance is		
		vation the facility failed to		submitted in compliance with applicabl		
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE	

Electronically Signed

08/30/2018

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING (X3) DATE SURV					
		345419	B. WING			C 08/17/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
LEVINOT	N			1	7 CORNELIA DRIVE		
LEXINGTO	ON HEALTH CARE CENT	EK		LEXINGTON, NC 27292			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	' '		F	600			
	'	ent free of abuse for 1 of 1			law and regulation. To demonstrate		
	_	d for abuse, Resident #4.			continuing compliance with applicable l	law,	
	, -	tilize information in the			the center has taken or will take the		
		summary and information			actions set forth in the following allegat	ion	
		r to develop and implement			of compliance. The following credible		
		ct Resident #4 from being ember on 7/30/18. Resident			allegations constitutes the center □s allegation of compliance. All alleged		
	,	ks on his back and a red			deficiencies have been or will be		
	area on his face as a				completed by the dates indicated.		
					Sompleton by the duties maistace.		
		pegan on 7/30/18 when			F600		
		buse of Resident #4 and did					
		ct the resident and was			The plan of correcting the specific		
	I .	when the facility provided			deficiency. The plan should address the	е	
		ceptable credible allegation			processes that lead to the deficiency		
		dy Removal. The facility			cited;		
	I .	out of compliance at a lower TD" (no harm with the			" Deficient practice □ the facility did	not	
	, .	n minimal harm that is not			utilize the information contained in the	ΠΟι	
	immediate jeopardy)				hospital discharge summary or		
	systems put into place				information from family member #2 to		
					implement interventions to protect		
	Findings included:				resident from spousal abuse during his	;	
					stay. The reason why the facility did no	ot .	
	I .	4's Hospital Discharge			implement any supervised visitation is		
	1	/18 revealed the hospital			because the interdisciplinary team did	not	
		dent #4 being abused and it			recognize the concern with potential		
		Protective Services. The			continued abuse. Family member #2 v		
		also noted the nursing staff eral witnessed episodes of			recently appointed Healthcare Power o		
	Family Member #1 ve	•			Attorney (HPOA) due to hospital initiate Adult Protective Services (APS)	s u	
	1	including slapping his leg,			involvement. The new family member		
	_	rowing restraints at him.			#2/HPOA did not request supervised		
		nary further revealed the			visitation to family member #1. Family		
		their abuse protocol and			member #2 was aware that Family		
		ber #1 to be accompanied			member #1 would be visiting daily.		
	by security when she	•			Therefore, the facility did not implemen	ıt	
	, , ,				any additional interventions to further		
	A telephone interview	with Family Member #2 on			protect the resident during his stay.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345419	B. WING			С
		345419	B. WING _			8/17/2018
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
I FXINGTO	N HEALTH CARE CENT	FR		17 CORNELIA DRIVE		
LLXIIIOIC	NI HEALIH OAKE OLKI	EK		LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From page 8/15/18 at 12:12 pm i	e 2 revealed she arrived at the	F 60	00 " While visiting on July 30,	2018. family	
	facility on 6/27/18 bet the facility to be admi stated she arrived ea hospital had involved due to Family Membe during his hospital sta stated she had told th	fore Resident #4 arrived at tted. Family Member #2 rly to let the facility know the Adult Protective Services er #1's abuse of Resident #4 ay. Family Member #2 ne Admission Director that eeded to be watched closely		member #1 slapped resident in his room. This incident was by nurse #1 who was across another resident □s room. At nurse #1 was administering a feeding to a resident. Unfortu knowing to rescue and report immediately, the reason why not intervene immediately is the did not think quickly enough the side of the state o	on the back s witnessed the hall in the time, bolus tube nately, while nurse #1 did pecause she	
	8/15/18 at 2:10 pm recame to the facility or was admitted to the face were allegations of all #1 at the hospital and Services case was op Director stated the Cahospital told her Fam Resident #4 while he Admission Director state into a semiprivate root other interventions we Resident #4. She als	pened. The Admission ase Manager from the ily Member #1 had swatted was in the hospital. The rated Resident #4 was put om at admission, but no ere put into place to protect so stated the facility had not lt Protective Services to get		help, and made the decision bolus tube feeding. As soon could safely finish she exited immediately address the situatime, a second incident betwee member #1 and resident had and staff had already separat "Facility Action o Visual assessment of residence by Nurse immediately feabuse, for any signs of bruish bleeding, agitation/anxiety noted on the mid-back area ared color to right cheek area. o Family member #1 was at the local police on July 30, 20	to finish the as nurse #1 the room to ation. By this een family occurred eed them. sident body bllowing ng, redness, 3 red areas and a slight arrested by b18. There	
	interview on 8/15/18 interdisciplinary Team #1's abuse of Reside during morning meeti Resident #4 was admimplement a care pla the risk of abuse. Th Planner stated Family Director of Nursing an	n discussed Family Member nt #4 while in the hospital ng the morning after nitted but he did not n or interventions regarding		was a court order issued stati was not to visit her husband a Therefore, she was not allow on facility property during res remainder of stay in the facilit Reception and nursing staff waware of court order restriction prohibiting visitation to reside facility. Resident is no longer The procedure for implement acceptable plan of correction	at the facility. ed visitation ident⊡s ty. were made ons nt and in facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	E CONSTRUCTION	I ' '	(X3) DATE SURVEY COMPLETED	
		345419	B. WING			
NAME OF D		345419			08/	17/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LEXINGTO	ON HEALTH CARE CENT	rer		17 CORNELIA DRIVE		
				LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 3	F 600			
	should implement the	e interventions.		specific deficiency cited;		
	Review of the Medica revealed he was adm 6/27/18 from the hosp fracture related to a function of the physical Abuse Confidence of the Physician on 6/30 Resident #4 was adm 6/27/18. The History revealed there was confidence of the physician on 6/30 Resident #4 was adm 6/27/18. The History revealed there was confidence of the physician on 6/30 Resident #4 was adm Adult Protective of Review of Resident #4 Minimum Data Set (M. 7/4/18 revealed he wimpaired, he was abled)	al Record for Resident #4 hitted to the facility on pital with diagnoses of all at home, Parkinson's , Dementia and Adult irmed. and Physical Examination by 0/18 at 10:27 am revealed hitted from a hospital on y and Physical Exam also oncern for spouse abuse Services was involved.		" The Director of Nursing (DO Regional Nurse Consultant compone-on-one education to Nurse # regarding prompt reporting of any resident abuse and providing a senvironment for the resident durit on August 16, 2018. Included in training was the following compowhat to do if abuse is suspected, notify for abuse allegations, timel reporting of abuse concerns, and protecting the resident from abus immediate intervention. In-servicincluded calling out for help from staff members if physically unable any witnessed abuse. "The Director of Nursing (DO Regional Nurse Consultant compeducation on August 15, 2018 for	oleted 21 21 21 21 21 21 21 21 21 21 21 21 21	
	assistance of one sta in the bed and extens members for transfer was dependent on sta The Director of Nursi 8/15/18 at 1:35 pm. 3 there was an open Ad open for Resident #4 6/27/18. She also sta her she suspected Re by Family Member #2 The Director of Nursi a semiprivate room a intervention the facilit Resident #4 from bei Nursing stated Family	aff member for moving about sive assistance of two staff ring in and out of bed and aff for eating. In a was interviewed on she stated she was told dult Protective Services case when he was admitted on ated Family Member #2 told esident #4 had been abused a during his hospital stay. In a stated Resident #4 was in and that was the only by put into place to protect ang abused. The Director of		department heads to include: Abuse/Neglect/Misappropriation// Initial Reporting Guidelines. On A 15, 2018, education was complet the following department heads: o 1) Administrator o 2) Director of Nursing o 4) Business Office Manager o 5) Human Resources o 6) Dietary Manager o 7) Receptionist o 8) Discharge Planner/Social o 9) Environmental Services M o 10) Rehab Director o 12) Activity Director o 13) Medical Records o 14) Maintenance Director Remaining nursing staff, dies	Crime □ August ted with Services ⁄lanager	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345419	B. WING _			1	C /17/2018
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	1772010
				1	7 CORNELIA DRIVE		
LEXINGTO	ON HEALTH CARE CEN	TER			EXINGTON, NC 27292		
()(1) ID	STIMMADA S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	ge 4	F	600			
	when the incident or	ccurred.			environmental staff, and therapy staff		
					began training on August 15, 2018.		
	An Incident Report of	dated 7/30/18 at 11:18 am			Included in this training are the following	ng	
		aw Resident #4's Family			components: what to do if abuse is	J	
		mber #1) hit him on his right			suspected, who to notify for abuse		
	shoulder and then p	ropelled him down the hall			allegations, timely reporting of abuse		
	with her hand over h	nis mouth. The report also			concerns, and protecting the resident		
		ate Dietician also observed			from abuse by immediate intervention.		
	_	(Family Member #1) with her			In-services also included for staff to ca		
		ent's mouth and told him to			out for help from other staff members i	f	
	-	he Dietician witnessed Family			they are physically unable to stop any		
		sident #4 in the mouth and tell			witnessed abuse. 145 out of 153		
		. The Incident Report stated			employees have completed the training	-	
		Nurse Supervisor who that Family Member #1 hit			" Any employee that did not receive education will be removed from the	rine	
		he back, covered his mouth			schedule until education is completed.		
		lapped him in the mouth so			" MDS coordinator reviewed discha		
	-	eak and would not let him go			summaries of current residents on Aug	-	
	to bed.	3 .			16, 2018 for history of abuse or APS concerns. No other residents were	,	
	The Payroll Represe	entative was interviewed on			identified as at risk for abuse or require	3	
	-	and stated she was at her			protection due to history of abusive		
	desk on 7/30/18 and	l heard a man yelling save			situations.		
		got up and went to see what					
		e Payroll Representative			The monitoring procedure to ensure th		
		4 was at the end of the			the plan of correction is effective and the		
		wheelchair with Family			specific deficiency cited remains correct		
		nim. She stated Family			and/or incompliance with the regulator	y	
	him in his right uppe	around Resident #4 and hit r arm. The Payroll			requirements;		
	Representative state	ed she went back to the office			" Once a referral is received for a ne	ew	
	-	sor, the Business Office			admission to the facility, the Admission	1	
	•	happened. She stated she			Director was instructed on 8/16/18 to		
	•	tervene when Family Member			review the discharge summary for		
	#1 hit Resident #4.				potential abuse allegations or concerns		
	The O				Administrator will audit 50% of all new		
	-	cian was interviewed on			admission discharge summaries for		
		and stated she was sitting at			abuse concerns and to ensure		
	ner desk on 7/30/18	and heard a man screaming			appropriate interventions have been		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345419	B. WING			C 8/17/2018
	ROVIDER OR SUPPLIER ON HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292		0/17/2010
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F 600	out her office door and pushing Resident #4 building with her hand slapped him in the net Corporate Dietician's turned the wheelchaint toward Resident #4's in the same area. The she went to report the Administrator but did to An interview with Nurrevealed on 7/30/18's member (Family Menfrom the room across Member #1 hit him in arm/shoulder area and down the hall toward the front of the building hand over his mouth the hall because he will did not intervene or considerable to the incident on 7/30/18 abused by Family Mewas told by the MDS Administrator wanted assessment, incident from staff about the instated she was getting when Nurse #1 told him #1 hit Resident #4. To stated when Nurse #1 Family Member #1 hit Resident #1 hit Resident #1 hit Resident #4.	him. She said she looked d saw Family Member #1 towards the front of the d over his mouth and she ck/head area. The tated Family Member #1 around and headed back room and then hit him again to e Corporate Dietician stated to incident to the not attempt to intervene. See #1 on 8/15/18 at 2:00 pm she saw Resident #4's family his right upper d then immediately started the nurses' desk and then ag. She stated she had her as she was moving down was yelling. She stated she hall for help but did notify the m the Nursing Supervisor to estated she did not witness 8 when Resident #4 was mber #1. She stated she Coordinator that the	F 60	implemented, if necessary, w month, every other week x 2 monthly x 3 months. "The Director of Nursing (instructed on 8/16/18 that effeimmediately, if abuse concernidentified at admission, the AD Director will notify the Director (DON). The Director of Nursing designee, will implement a caprotective interventions, such supervised visitation, for any admission identified with ong investigation concerns Date of compliance is August The Administrator is responsi implementing the acceptable correction.	(DON) was ective ns are dmission or of Nursing ing (DON), or are plan and a as new oing abuse	

D 19910	7/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292	7/2010
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
hit at the entrance hall to the building. The Nursing Supervisor stated when she did the skin assessment for Resident #4 on 7/30/18 he had three red marks on his back and a red area on his face. The Business Office Manager was interviewed on 8/15/18 at 2:55 pm. She stated the Payroll Representative reported to her Family Member #1 had hit Resident #4 in the Entrance Hallway of the facility on 7/30/18. She stated she went out into the hallway and followed Family Member #1 and Resident #4 into the Family Room. She stated she asked Family Member #1 if she hit Resident #4 and Family Member #1 if she hit Resident #4 and Family Member #1 stated she had and she could hit him whenever she wanted since she was his Power of Attorney. The Business Office Manager stated the Administrator arrived at that time and told Family Member #1 she should leave, and he was calling the Police. The Incident/Investigation Report dated 7/30/18 from the police department revealed on 7/30/18 at 1:10 pm the Administrator reported a "domestic assault" regarding Resident #4. The report stated the Police Officer spoke with Resident #4 and he told the officer Family Member #1 had hit him on the back three times and covered his mouth. The Police Officer's report stated he took witness statements and a warrant was obtained for Family Member #1 for simple assault and assault on a handicapped person. A phone interview on 8/16/18 at 6:00 pm with the Police Officer revealed Resident #4 stated Family Member #1 had hit him multiple times in the head and had held her hand over his mouths to that he	

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	ROVIDER OR SUPPLIER ON HEALTH CARE CENT		12	S 1	TREET ADDRESS, CITY, STATE, ZIP CODE 7 CORNELIA DRIVE LEXINGTON, NC 27292	J 08/	17/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Maintenance Director room 211A, where the	16/18 at 10:16 am with the revealed the distance from eresident resided, to the then back to the family	F	600			
	Jeopardy on 8/15/18 On 8/17/18 the facility credible allegation of dated 8/16/18 that ind	/ provided an acceptable immediate jeopardy removal					
	information contained summary or information to implement intervent from spousal abuse of why the facility did not visitation is because the concontinued abuse. Farecently appointed He (HPOA) due to hospit "Protective Services (family member #2/HF supervised visitation member #2 was awar would be visiting daily not implement any acfurther protect the research abuse of summary and further protect the research would be suppressed to the research abuse of the summary and the s	mily member #2 was ealthcare Power of Attorney cal-initiated Adult (APS) involvement. The new POA did not request to family member #1. Family re that Family member #1 //. Therefore, the facility did Iditional interventions to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP COI 17 CORNELIA DRIVE LEXINGTON, NC 27292	DE	00/11/2010
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F 600	incident was witness across the hall in and time, nurse #1 was a feeding to a resident. knowing to rescue ar reason why nurse #1 immediately is becaue nough to yell out for to finish the bolus tub nurse #1 could safely to immediately addres a second incident be and resident had occintervening appropriate Facility Action oVisual assessment Nurse immediately for for bruising, redness, 3 red areas noted on slight red color to right oFamily member #1 police on July 30, 20 issued stating that shusband at the facility allowed visitation on resident's remainder Reception and nursing court order restriction	on the back in his room. This ed by nurse #1 who was other resident's room. At the dministering a bolus tube. Unfortunately, while and report immediately, the did not intervene use she did not think quickly help and made the decision of feeding. As soon as of finish she exited the room as the situation. By this time, tween Family Member #1 curred and staff were already utely. The mid-back area and a not cheek area. Was arrested by the local and the resident of the was not to visit her ye. Therefore, she was not facility property during	F	600		
	The procedure for implan of correction for The Director of Nursi Nurse Consultant cor	plementing the acceptable the specific deficiency cited; ng (DON) and Regional mpleted one-on-one 1 regarding prompt reporting				

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	ROVIDER OR SUPPLIER DN HEALTH CARE CENT	l	1	s 1	TREET ADDRESS, CITY, STATE, ZIP CODE 7 CORNELIA DRIVE EXINGTON, NC 27292	<u> U87</u>	17/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	environment for the re August 16, 2018. Inc following components suspected, who to no timely reporting of about protecting the resider intervention. In-service for help from other state unable to stop any with the Director of Nursing Nurse Consultant conduction 15, 2018 for department Abuse/Neglect/Misap Reporting Guidelines education was compled department heads: o 1) Administrator o 2) Director of Nursing Abuse/Neglect/Misap Reporting Guidelines education was compled department heads: o 1) Administrator o 2) Director of Nursing Abuse/Neglect/Misap Reporting Guidelines education was compled department heads: o 1) Administrator o 2) Director of Nursing Abuseness Official Official Section 10 (a) Discharge Pla o 3) Discharge Pla o 9) Environmental o 10) Rehab Direction 12) Activity Direction 13) Medical Reccount 14) Maintenance Remaining nursing step environmental staff, a training on August 15 training are the follow if abuse is suspected	at abuse and providing a safe desident during abuse on cluded in this training was the set what to do if abuse is tify for abuse allegations, use concerns, and at from abuse by immediate desides also included calling out aff members if physically the tressed abuse. In (DON) and Regional impleted education on August ent heads to include: propriation/Crime - Initial. On August 15, 2018, eted with the following increase are manager to control of the properties of the propertie	F	600			

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F 600	for staff to call out for members if they are witnessed abuse. In have completed the Any employee that will be removed from is completed. MDS coordinator re of current residents history of abuse or residents were iden require protection distructions. The monitoring proof correction is effect deficiency cited remincompliance with the Once a referral is rethe facility, the Admon 8/16/18 to review potential abuse alle Administrator will audischarge summariaensure appropriate implemented, if necevery other week x months.	ion. In-services also included or help from other staff physically unable to stop any 45 out of 153 employees	F 600				
	immediately, if abus admission, the Adm DON. The DON, or care plan and prote	se concerns are identified at ission Director will notify the designee, will implement a ctive interventions, such as n, for any new admission					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345419	B. WING		C 08/17/2018
	ROVIDER OR SUPPLIER	ΓER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292	1 00/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 600	concerns. Date of compliance i	ng abuse investigation s August 16, 2018 responsible for implementing	F 60	0	
	removal was validate which removed the In Validation of the facil Immediate Jeopardy with Nurse #1, RN S Dietician, Director of Admission Director, I Business Office Man Nurse Assistants, Ho Maintenance Staff, a facility had educated abuse is suspected, allegations, timely re and protecting the reimmediate interventic summaries of all curron 8/16/18 for any ris further incidents hap Admission Director wadmissions for abuse The Administrator win admission discharge concerns and ensure implemented. The Athe Director of Nursin identified at admission Nursing will implemented interventions to protect had no new admissions	on for Immediate Jeopardy and on 8/17/18 at 4:00 pm, mmediate on 8/16/18. ity's credible allegation of removal included; Interviews upervisor, Corporate Nursing, Discharge Planner, Payroll Representative, ager, and multiple Nurses, busekeepers, Therapist, and Dietary staff revealed the the staff on "what to do if who to notify for abuse porting of abuse concerns, sident from abuse by			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345419	B. WING		C 08/17/2018		
	ROVIDER OR SUPPLIER DN HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292	00/17/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE COMPLETION		
F 600	Continued From page been implemented.	: 12	F 60	0			
F 607 SS=J	Develop/Implement A CFR(s): 483.12(b)(1)-		F 60	7	9/14/18		
	§483.12(b) The facility implement written pol	y must develop and icies and procedures that:					
	§483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re	ion of residents and					
	§483.12(b)(2) Establisto investigate any suc	sh policies and procedures th allegations, and					
	paragraph §483.95,	training as required at					
	Based on record revi interviews, and obser develop abuse policie protection of residents their abuse policies at for 1 of 1 residents in Resident #4. The fac member abuse on 7/3 Resident #4 having the	s and failed to implement and procedures in prevention estigated for abuse, ility failed to prevent family 80/18 which resulted in aree bruised areas to his o his face.		F607 Plan of Correction This Plan of Correction is submitted i compliance with applicable law and regulation. To demonstrate continuin compliance with applicable law, the chas taken or will take the actions set in the following allegation of compliar The following Plan of Correction constitutes the center sallegation of	ng center forth nce.		
	observed abuse of Reintervene to protect the jeopardy was remove facility provided an act of removal. The facility of compliance at a D for more than minima	regan on 7/30/18 when staff esident #4 and did not he resident. The immediate d on 8/16/18 when the exceptable credible allegation ty continues to remain out (no harm with the potential I harm that is not immediate ty to amend the abuse		compliance. All alleged deficiencies been, or will be completed by the dat indicated. The plan of correcting the specific deficiency. The plan should address processes that lead to the deficiency cited;	the		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	` ′	SURVEY PLETED
		345419	B. WING				C / 17/2018
NAME OF D	ROVIDER OR SUPPLIER	5.67.15		27	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	/1//2016
NAME OF T	NOVIDEN ON 3011 EIEN				CORNELIA DRIVE		
LEXINGTO	ON HEALTH CARE CE	NTER					
	T			L	EXINGTON, NC 27292		T
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APF DEFICIENCY)				(X5) COMPLETION DATE
F 607	Continued From page	F	607				
	policy to include pr	otection of residents from			" Deficient practice □ the facility fail	ed	
		ure monitoring systems put into			to develop and implement abuse polici		
	place are effective	- ·			and procedures that include intervenin		
					and protection of residents from abuse	-	
	Findings included:				Facility Action		
					o Facility developed a four-question	test	
	A review of the fac	-			that is specific to what to do if abuse is		
		sappropriation/Crime Policy with			suspected, who to report it to and whe	٦,	
		f 11/22/16 revealed the facility's			and what to do if abuse is witnessed.		
	•	atients of the Center have the			The proceeding for implementing the		
	1	e from verbal, sexual, mental e, corporal punishments,			The procedure for implementing the acceptable plan of correction for the		
		on including abuse facilitated			specific deficiency cited;		
		the use of technology, and			specific deficiency cited,		
	_	and physical restraints except			" All staff were educated by the Dire	ector	
		nd/or as authorized in writing			of Nursing (DON), Staff Development		
		d "All employees are			Coordinator (SDC), or designee on wh	at	
	responsible for rep	orting to the Administrator any			to do if abuse is suspected, who to rep	ort	
	and all suspected	or witnessed incidents of			it to and when, and what to do if abuse	is	
		lect, theft, exploitation and/or			witnessed.		
		patient as well as reasonable			" All new employees will be educate	:d	
		e against a patient". The			by the Staff Development Coordinator		
	'	de intervening or protection of abuse is observed.			(SDC) or designee during orientation.		
	the resident when	abuse is observed.			The monitoring procedure to ensure th	at	
	The Discharge Sur	mmary from the hospital dated			the plan of correction is effective and the		
		he hospital had concerns for			specific deficiency cited remains correct		
		eported to Adult Protective			and/or incompliance with the regulator	y	
	Services. The Dis	charge Summary also noted			requirements;		
	_	ad documented several					
		s of Family Member #1 verbally			" The Administrator or designee will		
		sing Resident #4 including			5 employees the four questions weekly		
		oking at him, and throwing			four weeks, and 5 employees monthly		
		The Discharge Summary			five months. The findings will be review	/ea	
		e hospital had initiated their d required Family Member #1			at the quarterly QAPI meetings. Date of compliance is September 14,		
		by security when she visited			2018		
	Resident #4.	2 2, occasing which one visited			The Administrator is responsible for		
					implementing the acceptable plan of		

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		345419	B. WING_			1	C 17/2018
	ROVIDER OR SUPPLIER DN HEALTH CARE CENT	ER		17	REET ADDRESS, CITY, STATE, ZIP CODE CORNELIA DRIVE EXINGTON, NC 27292	1 00/	17/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 607	8/15/18 at 12:12 pm r facility on 6/27/18 bef the facility to be admi stated she arrived earnospital had involved due to Family Member during his hospital stated she had told the Family Member #1 newhen she visited Res. An interview with the 8/15/18 at 2:10 pm recame to the facility or was admitted to the fawere allegations of at #1 at the hospital and Services case was op Director stated the Cahospital told her Famil Resident #4 while he Admission Director stated the Cahospital told her Famil Resident #4. She also attempted to call Aduldetails about the incidivisits for Family Mem The Director of Nursing 8/15/18 at 1:35 pm. Statempted to call Aduldetails about the incidivisits for Family Mem The Director of Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties and properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties and properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties and properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties and properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #4 She also stated Famil suspected Resident #5 Family Member #1 during properties was an open Acopen for Resident #5	with Family Member #2 on evealed she arrived at the ore Resident #4 arrived at ted. Family Member #2 rly to let the facility know the Adult Protective Services er #2's abuse of Resident #4 ay. Family Member #2 le Admission Director that eeded to be watched closely ident #4. Admission Director on evealed Family Member #2 land Adult Protective Resident #4 acility and told her there has against Family Member I an Adult Protective lened. The Admission ase Manager from the land Member #1 had swatted was in the hospital. The lated Resident #4 was put at admission, but no lere put into place to protect to stated the facility had not let Protective Services to get dent or provided supervised ber #1. Ing was interviewed on She stated she was told dult Protective Services case when he was admitted. Ity Member #2 told her she let had been abused by uring his hospital stay. The lated Resident #4 was in a	F	607	correction.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345419	B. WING _			C 08/17/2 (018
	ROVIDER OR SUPPLIER DN HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292			<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BI) TO THE APPROPRIA CIENCY)	-	(X5) MPLETION DATE
F 607	Resident #4. The Dir Family Member #1 ha until 7/30/18 when the Director of Nursing st morning meeting the was admitted but she interventions regardir. The facility's Discharginterview on 8/15/18 a Interdisciplinary Team #1's abuse of Resided during morning meeting Resident #4 was admimplement intervention abuse. An interview on 8/15/Social Worker revealed Member #1's history Director. The Social Member #1 came into Resident #4 was adm Member #1 told her swrist with his restraint Social Worker stated conversation with Farimplement intervention. A History and Physical Physician on 6/30/18 Resident #4 was adm 6/27/18. The History revealed there was conducted and Adult Protective stated there was admitted the protective stated the protective s	y put into place to protect ector of Nursing stated the ad visited daily unsupervised e incident occurred. The ated they had discussed in morning after Resident #4 did not implement ag the risk of abuse. The protect of the protect	Fé	907			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345419	B. WING			1	C 17/2018
	ROVIDER OR SUPPLIER DN HEALTH CARE CENT			17 CC	ET ADDRESS, CITY, STATE, ZIP CODE DRNELIA DRIVE INGTON, NC 27292	1 06/	17/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	Dementia and Adult I His comprehensive Massessment dated 7/moderately cognitive understand others ar He required extensive member for moving a extensive assistance transferring in and out on staff for eating. An Incident Report darevealed Nurse #1 sa Member (Family Member (Family Member (Family Member (Family Member (Hand over the Family Member (Hand over the resident "shut up" and then the Member #1 slap Reshim to shut up again. Resident #4 told the completed the report him three times on the multiple times and slat that he could not spet to bed. The Payroll Represent 8/15/18 at 1:00 pm and desk on 7/30/18 and me. She stated she seemed a seemed and she stated she seemed as a seemed as a seemed and she stated she seemed as a seemed	Disease, Depression, Physical Abuse Confirmed. Minimum Data Set (MDS) 4/18 revealed he was by impaired, he was able to ad was understood by others. The assistance of one staff	F	607			
	entrance hall, in his v Member #1 behind hi	was at the end of the wheelchair with Family m. She stated Family around Resident #4 and hit					

_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	COMPLETED
		345419	B. WING		C 08/17/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292	00/1//2010
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 607	Representative star and told her superv Manager, what had did not attempt to in #1 hit Resident #4. stated she knew sh supervisor, but she intervene. The Business Offic 8/15/18 at 2:55 pm Representative rep #1 had hit Resident the facility. She star hallway and follower Resident #4 into the she asked Family Men she could hit him w was his Power of A Manager stated the time and told Famil leave, and he was a The Corporate Diet 8/15/18 at 1:30 pm her desk on 7/30/18 for someone to sav out her office door a pushing Resident # building with her has slapped him in the Corporate Dietician turned the wheelch	ted she went back to the office risor, the Business Office I happened. She stated she ntervene when Family Member The Payroll Representative the should report abuse to her was not aware she should e Manager was interviewed on She stated the Payroll orted to her Family Member that in the Entrance Hallway of ated she went out into the ed Family Member #1 and the Family Room. She stated Member #1 if she hit Resident in the family Room. She stated Member #1 stated she had and the herever she wanted since she torney. The Business Office to Administrator arrived at that the y Member #1 she should	F 60	7	
	in the same area. she went to report to	The Corporate Dietician stated			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		345419	B. WING			C
	ROVIDER OR SUPPLIER DN HEALTH CARE CENT			STREET ADDRESS, CITY, STATE, ZIP (17 CORNELIA DRIVE LEXINGTON, NC 27292	•	08/17/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· ·	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	report the abuse to the An interview with Nur revealed she saw Re (Family Member #1) I room across the hall. #1 hit him in his right and then immediately toward the nurses' debuilding. She stated mouth as she was money was yelling. She so or call for help but did On 8/15/18 at 2:40 printerviewed. She statincident on 7/30/18 was told by Family Mewas told by the MDS Administrator wanted assessment, incident from staff about the instated she was gettin when Nurse #1 told h #1 hit Resident #4. Twhen Nurse #1 report Member #1 hit Resident from the staff had so the entrance hall to the Supervisor stated whassessment for Resident. The Incident/Investigation.	ted she knew she should ted Administrator. se #1 on 8/15/18 at 2:00 pm sident #4's family member nit him in his room from the She stated Family Member upper arm/shoulder area started down the hall sk and then the front of the she had her hand over his oving down the hall because stated she did not intervene in notify the RN Supervisor. In the Nurse Supervisor was sed she did not witness the hen Resident #4 was mber #1. She stated she Coordinator that the her to obtain a skin report, and get statements incident. The RN Supervisor get statements from the staff er she saw Family Member he RN Supervisor stated ted she had seen Family tent #4 in his room it was seen Resident #4 being hit at the building. The RN en she did the skin lent #4 on 7/30/18 he had se back and a red area on	F	607		
	from the police depar	tment revealed on 7/30/18 istrator reported a "domestic				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345419	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	343413] 5	9	STREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	17/2018
	ON HEALTH CARE CENT	ER		1	7 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 607	stated the Police Office and he told the office him on the back three mouth. The Police O witness statements a for Family Member #' assault on a handicar Member #1 was later before the Magistrate \$2500.00 unsecured appear in court on 8/3 An observation on 8/3 Maintenance Director room 211A, where the entrance hallway and room was 221.5 feet. The Administrator wa Jeopardy of F607 on Lexington Health Car Compliance dated 8/3 This allegation of concompliance with applity To demonstrate continuing applicable law, the cette actions set forth in compliance. The folloconstitutes the center All alleged deficiencies completed by the date. The plan of correcting The plan should address the deficiency cited:	esident #4. The report cer spoke with Resident #4 r Family Member #1 had hit et times and covered his efficer's report stated he took and a warrant was obtained offor simple assault and oped person. Family arrested and appeared and released under a bond and is scheduled to 31/18. 16/18 at 10:16 am with the r revealed the distance from the resident resided, to the then back to the family s notified of Immediate 8/15/18 at 5:30 pm. The Credible Allegation of 15/18: Inpliance is submitted in icable law and regulation. Inuing compliance with then the following allegation of cowing credible allegation of sallegation of compliance. The sallegation of compliance.	F	607			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345419	B. WING				C 17/2018	
	ROVIDER OR SUPPLIER DN HEALTH CARE CENT			17	REET ADDRESS, CITY, STATE, ZIP CODE CORNELIA DRIVE EXINGTON, NC 27292	<u> 06/</u>	17/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 607	summary or informati to implement intervent form spousal abuse of why the facility did not visitation is because the not recognize the concontinued abuse. Fair recently appointed He (HPOA) due to hospit Services (APS) involvements are that Fair visiting daily. Therefore implement any addition protect the resident dependent on the incident was witnessed across the hall in another, nurse #1 was across the hall in another was witnessed across the hall in another was across the hall in another was witnessed across the hall in a	In the hospital discharge on from family member #2 hitions to protect resident during his stay. The reason of implement any supervised the interdisciplinary team diducern with potential mily Member #2 was eathcare Power of Attorney tal initiated Adult Protective evement. The new family donot request supervised ember #1. Family member #1 would be one, the facility did not conal interventions to further turing his stay. 30, 2018, family member #1 he back in his room. This end by nurse #1 who was other resident's room. At the diministering a bolus tube Unfortunately, while do report immediately, the	F	607				
	already intervening approximately Facility Action Visual assessment of	resident body done by						
	ivurse irrimediately to	llowing abuse, for any signs				ļ		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DN HEALTH CARE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292			17/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 607	red areas noted on the red color to right cheef color to July 30, 2018. The stating she was not to facility. Therefore, sho facility. Therefore, sho facility property dustay in the facility. Rewere made aware of prohibiting visitation to Resident is no longer. The procedure for implan of correction for the Director of Nursin Nurse Consultant correducation to Admission review of all new admission for the provident to admission of care can be created.	bleeding, agitation/anxiety-3 are mid back area and a slight ek area. as arrested by local police ere was a court order issued by visit her husband at the are was not allowed visitation aring resident's remainder of ecception and nursing staff court order restrictions or resident and facility. in facility. plementing the acceptable the specific deficiency cited: and (DON and the Regional appleted one-on-one on Director regarding the assion paperwork to include ation history or APS	F	607			
	of current residents on history of abuse or Afresidents were identification during a situations. The Director of Nursia	iewed discharge summaries In August 16, 2018 for IPS concerns. No other IPS as at risk for abuse or IPS use to history of abusive IPS (DON) and Regional IPS (DON)					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 607	Reporting Guidelines education was completed the teducation was completed the facility, the Admistrator 2) Director of Nursi 3) Business Office 4) Human Resource 5) Dietary Manager 6) Receptionist 7) Discharge Plann 8) Environmental S 9) Rehab Director 10) Activity Director 11) Medical Records 12) Maintenance Director 12) Maintenance Director 13 Medical Records 14 training are the follow if abuse is suspected allegations, timely related protecting the reimmediate intervention of staff to call out for members if they are witnessed abuse. 14 have completed the to 15 monitoring processor of correction is effect deficiency cited remain incompliance with the 16 monitoring with the 17 monitoring with the 18 monitoring with with 18 monitoring with 18 monitorin	propriation/Crime-Initial c. On August 15,2 018, leted with the following Ing Manager es Per/Social Worker Pervices Manager Ref, dietary staff, Ind therapy staff began is, 2018. Included in this Ing components: what to do il, who to notify for abuse porting of abuse concerns, sident from abuse by In. In-services also included in help from other staff physically unable to stop any is out of 153 employees raining. Redure to ensure that the plan ive and that specific	F 6	07			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DN HEALTH CARE CEN	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292	1 33/11/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 607	discharge summarie ensure appropriate i implemented, if nece every other week x 2 months.		F 607			
	admission, the Admi DON. The DON, or care plan and protect supervised visitation	designee, will implement a ctive interventions, such as a for any new admission and abuse investigation				
	Date of compliance The Administrator is the acceptable plan	responsible for implementing				
	Validation Informatio	on:				
	Jeopardy removal w Interviews with Nurs Corporate Dietician, Discharge Planner, A Representative, Bus multiple Nurses, Nur Housekeepers, Ther Dietary staff reveale the staff on "what to who to notify for abur reporting of abuse or resident from abuse The discharge summer	Admission Director, Payroll siness Office Manager, and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345419	B. WING		01	C 3/17/2018
NAME OF PROVIDER OR SUPPLIER LEXINGTON HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 17 CORNELIA DRIVE LEXINGTON, NC 27292		
(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 CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLETION ENCED TO THE APPROPRIATE	
F 607	future the Admission potential admissions concerns. The Admir new admission discharconcerns and ensure implemented. The Adthe Director of Nursin identified at admission Nursing will implement interventions to prote	incidents happened in the Director will review all for abuse allegations or nistrator will audit 50% of all arge summaries for abuse interventions have been dmission Director will notify g of any abuse concerns n and the Director of the care plan and the ct the resident. The facility ns since the allegation of	F 60			