		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345066	B. WING		06/13/2019
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	·
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 000	Initial Comments		E 000		
F 583	conducted on 06/10/ facility was found in c requirement CFR 483 Preparedness. Even	3.73, Emergency	F 583		7/8/19
SS=D	CFR(s): 483.10(h)(1)	5	F 503		//0/19
		nd Confidentiality. ght to personal privacy and or her personal and medical			
	telephone communication and meetings of familiation	edical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a			
	residents right to pers right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to	o the facility for the resident, ered through a means other			
	and confidential perso (i) The resident has the of personal and medi provided at §483.70(if federal or state laws.	sident has a right to secure onal and medical records. he right to refuse the release cal records except as ()(2) or other applicable			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				07/03/2019

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 583 Continued From page 1 F 583 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law This REQUIREMENT is not met as evidenced bv: ADDRESS HOW CORRECTIVE Based on record review observation, and staff interview, the facility failed to ensure privacy ACTIONS WILL BE ACCOMPLISHED during wound assessment and dressing change FOR THOSE RESIDENTS FOUND TO for 1 of 2 residents (Resident #37) observed for HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. pressure ulcers. Findings included: Resident #37 and her roommate were not able to state how they felt about lack of Resident #37 was admitted to the facility 4/15/10. privacy due to their cognition. The primary Review of a guarterly MDS (Minimum Data Set-a Treatment Nurse and the weekend tool used for resident assessment) dated 4/5/19 Treatment Nurse have been re-educated revealed Resident #37 had severe cognitive on resident privacy practices in impairment and displayed no behaviors or conjunction with performing any kind of rejection of care. Active diagnoses included, but treatment. All training/re-education will be were not limited to Alzheimer's disease, dementia completed by July 8, 2019. without behavioral disturbance, and depression. Resident #37 had 1 stage 2 pressure ulcer. ADDRESS HOW THE FACILITY WILL **IDENTIFY OTHER RESIDENTS HAVING** A care plan dated 4/5/19 read, "At risk for skin THE POTENTIAL TO BE AFFECTED BY breakdown/excoriation d/t (due to) decreased bed THE SAME DEFICIENT PRACTICE. mobility, incontinence, use of splints to legs and hx (history) of pedal edema. She has hx of The primary Treatment Nurse and the fungus to her toes, folds and redness to her heels weekend Treatment Nurse have been and buttocks. She has edema to LE (lower re-educated on resident privacy practices extremity). PU (pressure ulcer) stage 2 to left in conjunction with performing any kind of butt. treatment. The facility has conducted training on resident rights with an A wound assessment of Resident #37's heel emphasis on resident privacy for all staff written by the Wound Care Nurse and dated members. 6/11/19 read, in part, "Unstageable r/t (related to) SDTI (suspected deep tissue injury). Status ADDRESS WHAT MEASURES WILL BE "Improved". Identified 5/25/19. Not present upon PUT INTO PLACE OR SYSTEMIC admission. Length 2cm (centimeters) x (by) CHANGES MADE TO ENSURE THAT

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Facility ID: 923187

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 583 Continued From page 2 F 583 THE DEFICIENT PRACTICE WILL NOT Width 2.5cm. Weak, palpable pulses. Normal RECUR. surrounding tissue." An observation was conducted on 6/11/19 at The Director of Nursing or Designee will 10:00AM of a wound check and dressing change monitor treatments to ensure resident of Resident #37's heel was performed by the privacy practices are being protected. wound care nurse and Nurse Practitioner. Monitor two (2) treatments per week 1. Resident #37 was seated in a wheelchair with her for four (4) weeks; then roommate directly across and facing her. The 2. Monitor one (1) treatment per week privacy curtain which separated the residents for four (4) weeks; then remained opened throughout the wound 3. Monitor one (1) treatment monthly assessment and dressing change of her heel. until resolved by the Quality Assurance Neither resident was able to state how they felt Committee. about a lack of privacy relation to their cognition. INDICATE HOW THE FACILITY PLANS An interview was conducted with a Nursing TO MONITOR ITS PERFORMANCE TO Assistant (NA #1) on 6/11/19 at 3:35PM. She MAKE SURE THAT SOLUTIONS ARE stated resident privacy and dignity was SUSTAINED. maintained by closing the door, pulling the curtain and closing the blinds during care. Also, make The Director of Nursing or Designee will sure the resident was covered during care. monitor treatments to ensure resident privacy practices are being protected. An interview was conducted with the/Wound Care 1. Monitor two (2) treatments per week Nurse on 6/11/19 at 3:40PM. She stated for for four (4) weeks; then resident privacy you pulled the curtains, and 2. Monitor one (1) treatment per week closed the door and blinds. She also stated she for four (4) weeks; then typically completed wound care in a private area Monitor one (1) treatment monthly 3. of the resident's room. She stated she cannot say until resolved by the Quality Assurance why she had not ensure Resident #37's privacy Committee. during her morning wound care and assessment. She stated, "I usually make sure to pull the On a guarterly basis the Director of curtain. I don't know why I didn't this time. I guess Nursing will present the Quality Assurance it was just poor judgment." Forms to the Quality Assurance Committee for monitoring and An interview was conducted with the Director of recommended changes. Nursing on 6/11/19 at 3:55PM. She stated her expectation to maintain resident privacy and INCLUDE DATES WHEN CORRECTIVE dignity was to knock before entering, introduce ACTION WILL BE COMPLETED. yourself, speak to the resident about what you

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923187

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED
		345066	B. WING		06	6/13/2019
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	BROOK			748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 583	curtain was pulled. Sl	e 3 d make sure the privacy he also stated she expected esident informed throughout	F 583	All training/re-education will be con by July 8, 2019.	npleted	
F 637 SS=D	CFR(s): 483.20(b)(2) §483.20(b)(2)(ii) With determines, or should there has been a sigr resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standard	nin 14 days after the facility I have determined, that	F 637			7/8/19
	requires interdisciplin care plan, or both.) This REQUIREMENT by: Based on record rev interviews, the facility significant change MI tool used for resident	DS (Minimum Data Set-a assessment) within 14 days nge for 1 of 2 residents		ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISH FOR THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.	ТО	
	and re-admitted from 4/18/19 and 5/3/19. Review of a Quarterly Resident #28 was co	mitted to the facility 1/15/19 an acute care hospital on / MDS dated 4/4/19 revealed gnitively intact and had no of care. All Activities of		A Comprehensive Assessment after Significant Change was completed 14, 2019 and submitted on June 26 for Resident #28. ADDRESS HOW THE FACILITY W IDENTIFY OTHER RESIDENTS H THE POTENTIAL TO BE AFFECTE THE SAME DEFICIENT PRACTICE	June 5, 2019 /ILL AVING ED BY	

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 637 Continued From page 4 F 637 Daily Living (ADLs) required extensive Both MDS Nurses were re-educated on assistance, except eating which was completed Chapter 2 of the RAI Manual on with supervision. Resident #28 was occasionally completion of A Significant Change incontinent of urine and always incontinent of Assessment on June 26, 2019. bowel and had no limb impairments. Active diagnoses included anemia, diabetes mellitus, ADDRESS WHAT MEASURES WILL BE depression, heart disease, insomnia, lobar PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT pneumonia, myelopathy, benign prostatic hyperplasia, and muscle spasm of the back. THE DEFICIENT PRACTICE WILL NOT Resident #28 had no swallowing disorder and RECUR. received 25% (percent) or less of parenteral/IV (intravenous) feeding. The facility has implemented a system by which both MDS Nurses when doing an Review of a 5 Day MDS dated 5/10/19 revealed assessment will print the Quality Indicator resident #28 required extensive assistance for Worksheet on each resident and must eating, was frequently incontinent of urine, and review each worksheet to determine if a active diagnoses included anemia, diabetes significant change has occurred and mellitus, depression, heart disease, insomnia, submit a significant change assessment if lobar pneumonia, myelopathy, benign prostatic required. The MDS Nurse □s will file these worksheets in a notebook divided into hyperplasia, and muscle spasm of the back. As well as, urinary tract infection, paroxysmal atrial significant change completed fibrillation, abnormalities of gait and mobility, assessments and regular assessments. muscle weakness, diabetes mellitus with diabetic polyneuropathy, and dysphagia. Resident #28 INDICATE HOW THE FACILITY PLANS was assessed as having had a swallowing TO MONITOR ITS PERFORMANCE TO disorder with coughing and/or choking with meals MAKE SURE THAT SOLUTIONS ARE SUSTAINED. and medications, had a feeding tube, and received parenteral/tube feeding for 51% or more of his nutrition. The Director of Nursing or her Designee will complete a Quality Assurance A care plan dated 5/24/19 read, in part, "NPO Worksheet on at least 10% of all regularly (nothing by mouth) at this time and has a PEG scheduled assessments to include the (Percutaneous Endoscopic Gastrostomy-feeding) Quality Indicator Worksheets from the tube. Recent aspiration pneumonia-at risk for MDS notebook to determine that all further aspiration." Significant Changes were identified and submitted as follows: An interview was conducted with Resident #28 on 1. Review 10% per week for four (4) 6/10/19 at 9:00AM. He stated he had a cervical weeks: then fusion in April and that was when they inserted his 2. Review 10% bi-weekly until resolved

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923187

ATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY
nd plan of	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345066	B. WING		06/13/2019
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
ALSTON I	BROOK			748 OLD SALISBURY ROAD .EXINGTON, NC 27295	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 637	Continued From page	e 5	F 637		
	feeding tube.			by the Quality Assurance Committee	9.
F 640 SS=D	Coordinator on 6/12/ significant change Mi was established the of She also stated rega feeding tube would b the last area (ADLs) a feeding tube and w the tube so he was a was a change. He is himself, but wasn't gi formula. When he did week (14 day) time fr we should have set a change MDS at that from the hospital we would have a feeding done a significant cha	g Resident Assessments	F 640	On a quarterly basis the Director of Nursing will present the Quality Assu Forms to the Quality Assurance Committee for monitoring and recommended changes. INCLUDE DATES WHEN CORREC ACTION WILL BE COMPLETED. All re-education and new monitoring system will be put into place by July 2019.	TIVE
	a facility completes a facility must encode t each resident in the f (i) Admission assess (ii) Annual assessme (iii) Significant chang (iv) Quarterly review (v) A subset of items reentry, discharge, au	ng data. Within 7 days after resident's assessment, a the following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. e-sheet) information, if there			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 07/15/2019 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345066	B. WING		06/	/13/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALSTON E	BROOK			748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 640	after a facility complet a facility must be capa CMS System informat contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility encoded, accurate, and the CMS System, incl (i)Admission assessment (ii) Annual assessment (iii) Significant correct (v) Significant correct (v) Significant correct (v) Significant correct (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (face initial transmission of does not have an adm §483.20(f)(4) Data for transmit data in the for for a State which has by CMS, in the format approved by CMS. This REQUIREMENT by: The facility failed to tr not anticipated Minim	itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to its and data dictionaries, dardized edits defined by ittal requirements. Within a completes a resident's must electronically transmit and complete MDS data to fuding the following: nent. it. in status assessment. ition of prior full assessment. ion of prior quarterly upon a resident's transfer, ad death. e-sheet) information, for an MDS data on resident that	F 640	ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISH FOR THOSE RESIDENTS FOUND HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE.		

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Facility ID: 923187

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### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 640 Continued From page 7 F 640 Findings included: Resident #1 Assessment was transmitted Resident # 1 was admitted to the facility on June 21, 2019. 01/08/2019 with diagnoses that included atrial ADDRESS HOW THE FACILITY WILL fibrillation, hypertension, congestive heart failure, arthritis and anxiety. **IDENTIFY OTHER RESIDENTS HAVING** THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. An admission MDS for Resident # 1 dated 01/08/2019 revealed that resident # 1 was cognitively intact and planned to discharge to the Both MDS Nurses were re-educated on community. Chapter 5 of the RAI Manual on proper transmission of resident assessments on A review of the MDS transmission/ submission June 26, 2019. In addition the facility has record for Resident # 1 revealed that a discharge implemented a system by which all MDS was completed for Resident # 1 dated resident assessments will be logged on 01/31/2019 but the discharge MDS had not been the Alston Brook MDS Transmission received in the MDS data base by day 14 of MDS Log/QA. This Log contains the following completion or at any time after that. information: Resident name, Type assessment, ARD, PASRR Level, Wound On 06/12/2019 at 2:30 PM an interview was Type, RN sign by date, CAA completed, conducted with MDS nurse #1. MDS nurse #1 Transmitted by and Date transmitted. In revealed that she had completed the discharge addition this Log contains a QA Check MDS for Resident # 1 and had meant to include it Completed by and date completed. The in a submission file to be sent to the data base, MDS Nurses will enter all resident but for some reason it was missed and not added assessments on this Log and must to the file and had not been added to any file indicate when each assessment is since that time. transmitted, and by whom it was transmitted. On 06/12/2019 at 4:23 PM an interview with the facility administrator revealed that if an MDS ADDRESS WHAT MEASURES WILL BE record was not submitted to the data base for any PUT INTO PLACE OR SYSTEMIC reason the electronic computer system used by CHANGES MADE TO ENSURE THAT the facility would detect the closed/ completed file THE DEFICIENT PRACTICE WILL NOT and automatically send it to the data base as RECUR. required. The facility has implemented a system by which all resident assessments will be logged on the Alston Brook MDS Transmission Log/QA. This Log contains

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					OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345066	B. WING		06/13/2019
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETIC
F 640	Continued From page	ge 8	F 64	<ul> <li>the following information: Resider Type assessment, ARD, PASRR Wound Type, RN sign by date, C, completed, Transmitted by and D transmitted. In addition this Log c QA Check Completed by and date completed. The MDS Nurses will resident assessments on this Log must indicate when each assess transmitted and by whom it was transmitted.</li> <li>INDICATE HOW THE FACILITY F TO MONITOR ITS PERFORMAN MAKE SURE THAT SOLUTIONS SUSTAINED.</li> <li>The Director of Nursing or Design review the Alston Brook MDS Transmission Log/QA and compa Alston Brook MDS Transmission the CMS Submission Report – Fin Validation Report to ensure all Re Assessments are submitted in a t manner and sign and date as folke 1. Review/Compare Transmissi one time per week for four (4) we then</li> <li>Review/Compare Transmissi monthly until resolved by the Qua Assurance Committee.</li> <li>On a quarterly basis the Director Nursing will present the Quality A Forms to the Quality Assurance Committee for monitoring and</li> </ul>	Level, AA ate ontains a log all and nent is PLANS CE TO ARE lee will re the Log with hal esident imely bws: on Log eks; on Log lity

Event ID: C4RW11

Facility ID: 923187

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345066	B. WING		06/13/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.10.2010
ALSTON E	BROOK			1748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPR DEFICIENCY)	BE COMPLETIO
F 640	Continued From pag	e 9	F 640		
				INCLUDE DATES WHEN CORRECT ACTION WILL BE COMPLETED.	IVE
F 641 SS=E	Accuracy of Assessr CFR(s): 483.20(g)	nents	F 641	All re-education and new tracking system will be put into place by July 8, 2019.	tem 7/8/19
	resident's status. This REQUIREMENT by: Based on record revelopservations the fact the Minimum Data S residents reviewed for # 5, # 16, # 39, # 69 1500 with a level II F Screening and Resid comprehensive MDS at M 0300 and M 03 on the quarterly MDS Findings included: 1. Resident # 5 was 12/01/2018 with diag hypertension, Bipola anxiety, narcolepsy a A review of an admis for Resident # 5 data	or MDS accuracy. Residents and # 76 were not coded at A PASSR (Preadmission dent Review) on Ss. Resident # 19 was coded 10 with incorrect ulcer types S dated 03/28/2019. admitted to the facility on gnoses that included r disorder, atrial fibrillation,		ADDRESS HOW CORRECTIVE ACTIONS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. A correction assessment was complet June 12, 2019 and submitted on June 2019 on Residents #5, #16, #39, and to indicate correct Level II PASRR. A correction assessment was completed June 12, 2019 and submitted on June 2019 on Residents #76 to indicate cor Level II PASRR. A correction assess was completed and transmitted on June 14, 2019 on Resident #19 to indicate correct ulcer type. ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAV THE POTENTIAL TO BE AFFECTED THE SAME DEFICIENT PRACTICE.	O ted a 14, #69 d a 26, rrect nent ne

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 10 F 641 Resident PASSR Conditions or Conditions related Chapter 3 Section A of the RAI Manual on to ID (intellectual disability) or DD (developmental proper coding of the PASRR and Chapter disorder) at A1550. Resident # 5 was coded as 3 Section M on proper coding of wounds. cognitively intact. Re-education was completed on June 26, 2019. An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed ADDRESS WHAT MEASURES WILL BE that she was responsible to update current PUT INTO PLACE OR SYSTEMIC PASSR status levels as directed by the admission CHANGES MADE TO ENSURE THAT coordinator (AC). The SW revealed that she did THE DEFICIENT PRACTICE WILL NOT not code the MDS with PASR status and that the RECUR. DS nurses completed that section of the MDS. The SW revealed that PASSR levels were The facility has implemented a process updated or recorded on each resident face sheet where the Admissions Coordinator will in the medical record. The SW was not aware maintain a Level II PASRR Log on all that there were 6 residents in the facility with Level II PASRR residents within the Level II PASSR numbers. facility. In addition the New Admissions Report has been revised to include on all On 06/12/2019 at 11:35 AM an interview was new admissions the PASRR number and conducted with the facility AC. The AC revealed Level of the PASRR on all residents. The that on admission, she obtained each PASSR New Admissions Report is widely level status for each resident which she shared distributed throughout the facility by e-mail to include the MDS Nurses each time a with the SW and other team members in the weekday morning meetings. The AC revealed new admission is admitted into the facility. that she was responsible to enter each resident's This e-mail will notify the MDS Nurses of PASSR level in the medical record and that then any new Level II PASRR entering the the information was electronically documented on facility to be reported on the resident the resident's face sheet of the medical record. assessment. The MDS Nurses are The AC revealed that she did not communicate responsible to Log and track all Level II PASSR status with MDS nurses other than in the PASRR resident assessments on the morning meeting and that the AC did not know Alston Brook MDS Transmission Log/QA. how the information was recorded on MDSs. The AC revealed that the facility had only 1 resident The facility developed a Practitioner with a Level II PASSR number and that the Weekly Wound Rounding Report to be number was a lifetime number. The AC was not utilized by the Treatment Nurses and aware that the facility had 6 residents with Level II Practitioner on each resident requiring PASSR numbers. wound care. This is a comprehensive current assessment and treatment tool An interview conducted with MDS nurse #1 was that reflects the most current status of

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 11 F 641 conducted on 06/12/2019 at 2:30 PM. MDS nurse each resident wound in order to # 1 revealed the PASSR levels were discussed by accurately support MDS proper coding on the SW or the AC during the weekday morning resident assessment. Upon completing meetings and the MDS nurses were responsible this report, the Treatment Nurse is to code PASSR levels on comprehensive MDSs. responsible to place each individual report MDS nurse #1 revealed that she did not review in a binder that will be made available to resident face sheets for PASSR status when she the MDS Nurses to ensure they have the completed an MDS and had only looked for most current information for reporting on formal documentation form the North Carolina the resident assessment. The MDS Department of Health and Human Services Nurses are responsible to log and track all Division of Medical Assistance for PASSR resident wound assessments on the Notification information. MDS nurse # 1 revealed Alston Brook MDS Transmission Log/QA. that the facility did not share PASSR status of residents other than the morning meeting or by INDICATE HOW THE FACILITY PLANS the form on the resident medical record. MDS TO MONITOR ITS PERFORMANCE TO nurse #1 was not aware of 6 residents in the MAKE SURE THAT SOLUTIONS ARE facility with Level II PASSR numbers. SUSTAINED. On 06/12/2019 at 2:30 PM MDS nurse # 2 was The Administrator or his Designee will be interviewed and revealed that she was just responsible to ensure that the Admissions learning the MDS coding process and that she Coordinator is maintaining the Level II did not recall that she had coded any residents PASRR Log and utilizing the revised New Admission Report. The Administrator or with PASSR Level II status on an MDS that she completed. MDS nurse # 2 revealed that her his designee will review the Log and MDSs were reviewed by a corporate nurse and Admission Report on a regular basis as that the corporate nurse did not tell MDS nurse # follows: 2 that any PASSR Level II residents were Review the Log and Admissions 1. miscoded under A 1500. Both MDS nurse # 1 and Report once a week for 4 weeks; then # 2 revealed that after the MDSs were approved Review the Log and Admissions 2 by the corporate nurse the MDS nurses Report bi-weekly for 4 weeks; then transmitted the MDSs as coded. 3. Review the Log and Report Admissions monthly until resolved by the On 06/12/2019 at 4:23 PM an interview was Quality Assurance Committee. conducted with the facility administrator. The The Director of Nursing or her Designee is administrator revealed that he expected that MDSs be coded accurately and according to the responsible to ensure that all Level II Resident Assessment Instruction (RAI) manual. PASRRS are properly reported on the The facility administrator revealed that he resident assessment. The Director of believed that resident MDSs were not coded Nursing or Designee will compare the

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#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 12 F 641 correctly due to poor education and training. The Level II PASRR Log to the Alston Brook facility administrator revealed that he had just MDS Transmission Log/QA to ensure been made aware that the facility had 6 residents Level II PASRRS are reported properly as with Level II PASSR numbers. follows: 2. Resident # 16 was readmitted to the facility on Review/Compare the PASRR Log and 1. 07/25/2018 with diagnoses that included Transmission Log once a week for 4 intellectual disabilities, muscle weakness, weeks; then epilepsy and major depression. 2 Review/Compare the PASRR Log and Transmission Log bi-weekly for 4 weeks; A review of a significant change MDS dated then 01/06/2019 for Resident # 16 revealed that 3. Review/Compare the PASRR Log and Resident # 16 was not coded at A1500 with Transmission Log monthly until resolved Preadmission Screening and Resident Review by the Quality Assurance Committee. (PASSR) and that Resident # 16 was not coded at A1510 Level II Preadmission Screening and The Director of Nursing or her Designee is Resident PASSR Conditions or Conditions related responsible to ensure that Wounds are to ID (intellectual disability) or DD (developmental properly reported on the resident disorder) at A1550. Resident # 16 was coded as assessment. The Director of Nursing or unable to participate in the cognition assessment. Designee will compare the Practitioner Weekly Wound Rounding Reports to the An interview conducted with the facility social Alston Brook MDS Transmission Log/QA worker (SW) on 06/12/2019 at 11:14 AM revealed to ensure Wounds are reported properly that she was responsible to update current as follows: PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did 1. Review/Compare the Practitioner not code the MDS with PASR status and that the Weekly Wound Rounding Reports and DS nurses completed that section of the MDS. Alston Brook MDS Transmission Log/QA The SW revealed that PASSR levels were once a week for 4 weeks; then updated or recorded on each resident face sheet 2. Review/Compare the Practitioner in the medical record. The SW was not aware Weekly Wound Rounding Reports and that there were 6 residents in the facility with Alston Brook MDS Transmission Log/QA Level II PASSR numbers. bi-weekly for 4 weeks; then 3. Review/Compare the Practitioner On 06/12/2019 at 11:35 AM an interview was Weekly Wound Rounding Reports and conducted with the facility AC. The AC revealed Alston Brook MDS Transmission Log/QA that on admission, she obtained each PASSR monthly until resolved by the Quality level status for each resident which she shared Assurance Committee. with the SW and other team members in the

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	S FOR MEDICARE &		0.00	E CONCEDUCTION		O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · ·	E SURVEY PLETED
		345066	B. WING		06	6/13/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
ALSTON I	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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)	I SHOULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 13	F 64	1		
r 041	weekday morning met that she was respons PASSR level in the m the information was e the resident's face sh The AC revealed that PASSR status with M morning meeting and how the information w AC revealed that the with a Level II PASSF number was a lifetime aware that the facility PASSR numbers. An interview conducte conducted on 06/12/2 # 1 revealed the PAS the SW or the AC dur meetings and the MD to code PASSR levels MDS nurse #1 reveal resident face sheets f completed an MDS at formal documentation Department of Health Division of Medical As Notification information that the facility did no residents other than t the form on the reside nurse #1 was not awa facility with Level II PA	eetings. The AC revealed ible to enter each resident's edical record and that then electronically documented on eet of the medical record. she did not communicate DS nurses other than in the that the AC did not know was recorded on MDSs. The facility had only 1 resident R number and that the e number. The AC was not had 6 residents with Level II ed with MDS nurse #1 was 2019 at 2:30 PM. MDS nurse SR levels were discussed by ing the weekday morning 'S nurses were responsible s on comprehensive MDSs. ed that she did not review for PASSR status when she nd had only looked for n form the North Carolina a and Human Services ssistance for PASSR on. MDS nurse # 1 revealed t share PASSR status of he morning meeting or by ent medical record. MDS are of 6 residents in the ASSR numbers.	F 64	On a quarterly basis the Admi Director of Nursing will preser Assurance Forms to the Qual Assurance Committee for more recommended changes. INCLUDE DATES WHEN CO ACTION WILL BE COMPLET All re-education and new track will be put into place by July 8	nt the Quality ity nitoring and RRECTIVE ED. king system	
	interviewed and revea learning the MDS coo	ling process and that she had coded any residents				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/15/2019 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		(X3) DATE	
		345066	B. WING				06/	13/2019
NAME OF PF	ROVIDER OR SUPPLIER			Ş	STREET ADDRESS, CITY, STATE, ZIP COL	DE	-	
ALSTON E	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295			
								0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BI		(X5) COMPLETION DATE
F 641	MDSs were reviewed that the corporate nur 2 that any PASSR Ler miscoded under A 15 # 2 revealed that after by the corporate nurs transmitted the MDSs On 06/12/2019 at 4:2: conducted with the fa administrator revealed MDSs be coded accu Resident Assessment The facility administrato believed that resident correctly due to poor facility administrator r been made aware that with Level II PASSR r 3. Resident # 39 was 09/04/2015 with diagr palsy, anxiety and del A review of an MDS of that resident # 39 was coded at A1500 with the	<ul> <li>a # 2 revealed that her</li> <li>by a corporate nurse and</li> <li>cse did not tell MDS nurse #</li> <li>vel II residents were</li> <li>00. Both MDS nurse # 1 and</li> <li>r the MDSs were approved</li> <li>e the MDS nurses</li> <li>c as coded.</li> <li>3 PM an interview was</li> <li>cility administrator. The</li> <li>d that he expected that</li> <li>rately and according to the</li> <li>t Instruction (RAI) manual.</li> <li>ator revealed that he</li> <li>MDSs were not coded</li> <li>education and training. The</li> <li>evealed that he had just</li> <li>at the facility had 6 residents</li> <li>numbers.</li> </ul>	F	641				
	(PASSR) Conditions a coded at A 1550 with (intellectual disability) disorder). An interview conducted	ing and Resident Review and Resident # 39 was not Conditions Related to ID or DD (developmental ed with the facility social 2/2019 at 11:14 AM revealed ible to update current						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 07/15/2019 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	_	(X3) DATE : COMPL	SURVEY
		345066	B. WING			06/1	13/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
ALSTON	BROOK			4748 OLD SALISBURY ROLEXINGTON, NC 2729			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	coordinator (AC). The not code the MDS wit the DS nurses comple MDS. The SW reveal- updated or recorded of in the medical record. that there were 6 resi- Level II PASSR numb On 06/12/2019 at 11:3 conducted with the fa that on admission, sh level status for each r with the SW and othe weekday morning me that she was respons PASSR level in the m the information was e the resident's face sh The AC revealed that PASSR status with M morning meeting and how the information w AC revealed that the with a Level II PASSF number was a lifetime aware that the facility PASSR numbers. An interview conducte conducted on 06/12/2 # 1 revealed the PASS the SW or the AC dur meetings and the MD to code PASSR levels MDS nurse #1 reveal- resident face sheets f	as directed by the admission e SW revealed that she did h PASSR status and that eted that section of the ed that PASSR levels were on each resident face sheet The SW was not aware dents in the facility with ers. 35 AM an interview was cility AC. The AC revealed e obtained each PASSR esident which she shared r team members in the etings. The AC revealed ible to enter each resident's edical record and that then lectronically documented on eet of the medical record. she did not communicate DS nurses other than in the that the AC did not know vas recorded on MDSs. The facility had only 1 resident	F 64	.1			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/15/2019 APPROVED ). 0938-0391
STATEMENT OF DEFIC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		345066	B. WING _			06/	13/2019
NAME OF PROVIDER	R OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON BROOK					748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
forma Depai Divisi Notific that the reside the fo nurse facility On 00 interv learni did no with F comp MDSs that th 2 that misco # 2 re by the transr On 00 condu admir MDSs Resid The fa believ correc facility been with L	rtment of Health on of Medical As cation informatio he facility did not ents other than ti rm on the reside #1 was not away with Level II P/ 6/12/2019 at 2:30 iewed and revea ing the MDS cod of recall that she PASSR Level II s leted. MDS nurs were reviewed he corporate nurs mitted that after corporate nurs mitted the MDSs 6/12/2019 at 4:22 ucted with the fa- histrator revealed be coded accu- ent Assessment acility administra- red that resident ctly due to poor of y administrator re- made aware tha- u-evel II PASSR r sident # 69 was /2019 with diagr	form the North Carolina and Human Services sistance for PASSR in. MDS nurse # 1 revealed t share PASSR status of he morning meeting or by ent medical record. MDS are of 6 residents in the ASSR numbers. O PM MDS nurse # 2 was aled that she was just ling process and that she had coded any residents status on an MDS that she is a corporate nurse and se did not tell MDS nurse # vel II residents were 00. Both MDS nurse # 1 and r the MDSs were approved e the MDS nurses as coded. 3 PM an interview was cility administrator. The d that he expected that rately and according to the c Instruction (RAI) manual. itor revealed that he MDSs were not coded education and training. The evealed that he had just it the facility had 6 residents	F	i41			

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# FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 17 F 641 An MDS for Resident # 69 dated 05/14/2019 revealed that Resident # 69 had moderate cognitive impairment and was coded at A1500 with no Preadmission Screening and Resident Review (PASSR). Resident # 69 was not coded at A1510 with Level II Preadmission Screening and Resident Review (PASSR) Conditions and Resident # 69 was not coded at A 1550 with Conditions Related to ID (intellectual disability) or DD (developmental disorder). An interview conducted with the facility social worker (SW) on 06/12/2019 at 11:14 AM revealed that she was responsible to update current PASSR status levels as directed by the admission coordinator (AC). The SW revealed that she did not code the MDS with PASR status and that the DS nurses completed that section of the MDS. The SW revealed that PASSR levels were updated or recorded on each resident face sheet in the medical record. The SW was not aware that there were 6 residents in the facility with Level II PASSR numbers. On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	D: 07/15/2019 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	
		345066	B. WING			06/	13/2019
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON I	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641	AC revealed that the r with a Level II PASSF number was a lifetime aware that the facility PASSR numbers. An interview conducte conducted on 06/12/2 # 1 revealed the PAS the SW or the AC dur meetings and the MD to code PASSR levels MDS nurse #1 reveal resident face sheets f completed an MDS an formal documentation Department of Health Division of Medical As Notification information that the facility did nor residents other than the the form on the reside nurse #1 was not awa facility with Level II PA On 06/12/2019 at 2:30 interviewed and reveal learning the MDS cool did not recall that she with PASSR Level II s completed. MDS nurse MDSs were reviewed that the corporate nur 2 that any PASSRR L	facility had only 1 resident R number and that the e number. The AC was not had 6 residents with Level II ed with MDS nurse #1 was 2019 at 2:30 PM. MDS nurse SR levels were discussed by ing the weekday morning PS nurses were responsible is on comprehensive MDSs. ed that she did not review for PASSR status when she nd had only looked for n form the North Carolina a and Human Services sistance for PASSR on. MDS nurse # 1 revealed t share PASSR status of he morning meeting or by ent medical record. MDS are of 6 residents in the ASSR numbers. 0 PM MDS nurse # 2 was aled that she was just ding process and that she e had coded any residents status on an MDS that she set 2 revealed that her I by a corporate nurse and rse did not tell MDS nurse # 1 and r the MDSs were approved us the MDS nurses	F	641			

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 07/15/2019 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345066	B. WING			6/13/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE ) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 641	conducted with the fa administrator revealed MDSs be coded accu Resident Assessment The facility administration believed that resident correctly due to poor facility administrator r been made aware that with Level II PASSR r 5. Resident # 76 was 12/30/2011 with diagr intellectual disabilities function and convulsion A review of an annual revealed that Resider impairment and was of Preadmission Screen (PASSR). Resident # with Level II Preadmis Resident Review (PA Resident # 76 was no Conditions Related to DD (developmental di An interview conducted worker (SW) on 06/12 that she was respons PASSR status levels a coordinator (AC). The not code the MDS with DS nurses completed The SW revealed that updated or recorded of in the medical record.	3 PM an interview was cility administrator. The d that he expected that rately and according to the t Instruction (RAI) manual. ator revealed that he MDSs were not coded education and training. The evealed that he had just at the facility had 6 residents numbers. admitted to the facility noses that included s, borderline intellectual ons. MDS dated 05/15/2018 nt # 76 had severe cognitive coded at A1500 with no ing and Resident Review 76 was not coded at A 1510 ssion Screening and SSR) Conditions and ot coded at A 1550 with D (intellectual disability) or isorder). ed with the facility social 2/2019 at 11:14 AM revealed ible to update current as directed by the admission e SW revealed that she did h PASR status and that the I that section of the MDS.	F 64	1		

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# FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 641 Continued From page 20 F 641 Level II PASSR numbers. On 06/12/2019 at 11:35 AM an interview was conducted with the facility AC. The AC revealed that on admission, she obtained each PASSR level status for each resident which she shared with the SW and other team members in the weekday morning meetings. The AC revealed that she was responsible to enter each resident's PASSR level in the medical record and that then the information was electronically documented on the resident's face sheet of the medical record. The AC revealed that she did not communicate PASSR status with MDS nurses other than in the morning meeting and that the AC did not know how the information was recorded on MDSs. The AC revealed that the facility had only 1 resident with a Level II PASSR number and that the number was a lifetime number. The AC was not aware that the facility had 6 residents with Level II PASSR numbers. An interview conducted with MDS nurse #1 was conducted on 06/12/2019 at 2:30 PM. MDS nurse # 1 revealed the PASSR levels were discussed by the SW or the AC during the weekday morning meetings and the MDS nurses were responsible to code PASSR levels on comprehensive MDSs. MDS nurse #1 revealed that she did not review resident face sheets for PASSR status when she completed an MDS and had only looked for formal documentation form the North Carolina Department of Health and Human Services Division of Medical Assistance for PASSR Notification information. MDS nurse # 1 revealed that the facility did not share PASSR status of residents other than the morning meeting or by the form on the resident medical record. MDS nurse #1 was not aware of 6 residents in the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 07/15/2019 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	
		345066	B. WING		06/	13/2019
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZI	P CODE	
ALSTON E	BROOK			748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 641	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 facility with Level II PASSR numbers. On 06/12/2019 at 2:30 PM MDS nurse # 2 was interviewed and revealed that she was just learning the MDS coding process and that she did not recall that she had coded any residents with PASSR Level II status on an MDS that she completed. MDS nurse # 2 revealed that her MDSs were reviewed by a corporate nurse and that the corporate nurse did not tell MDS nurse # 2 that any PASSRR Level II residents were miscoded under A 1500. Both MDS nurse # 1 and # 2 revealed that after the MDSs were approved by the corporate nurse the MDS nurses transmitted the MDSs as coded. On 06/12/2019 at 4:23 PM an interview was conducted with the facility administrator. The administrator revealed that he expected that MDSs be coded accurately and according to the Resident Assessment Instruction (RAI) manual. The facility administrator revealed that he believed that resident MDSs were not coded correctly due to poor education and training. The facility administrator revealed that he believed that resident MDSs were not coded correctly due to poor education and training. The facility administrator revealed that he had just been made aware that the facility had 6 residents with Level II PASSR numbers. 6. Resident #19 was admitted to the facility on 10/3/18 with diagnoses of peripheral vascular disease, diabetes, hemiplegia, and depression. Resident #19's most recent Minimum Data Set Assessment, a quarterly assessment dated 3/28/19, revealed she was moderately cognitively impaired and required extensive assistance with turning in bed, transferring and toileting. The assessment further revealed Resident #19 had 8 unstageable deep tissue injury wounds.		F 641			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 07/15/2019 FORM APPROVED MB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE SURVEY COMPLETED
		345066	B. WING			06/13/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE	
ALSTON E	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page	22	F 64	1		
	had a deep tissue inju left great toe, left seco right calf.	/19 revealed Resident #19 ury to her left heel, left foot, ond toe, right great toe and d 3/21/19 written by the				
	Physician revealed R	esident #19 had 2 deep and 4 arterial wounds during				
	6/12/19 at 10:48 am s wounds were all arter when Resident #19 h the Wound Nurse had ulcers in the Wound A electronic documenta not able to change the	tions system and she was e assessment of the wounds ated they were still listed as ressure Ulcers in the				
	Minimum Data Set (M Physician had change Resident #19's wound 3/21/19 Physician's N their electronic docum allow the Wound Nurs assessment of the wo system so the MDS N assessment of the wo MDS Nurse stated the weekly to discuss wo not participate in the w	ds to arterial wounds on the lote. The MDS Nurse stated mentation system did not se to change the bunds in the computer lurse was not aware the bunds had changed. The e administrative team met unds but the MDS Nurse did				
	11:02 am revealed his	s expectation was the MDS				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345066	B. WING		06/13/201
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
ALSTON BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	FULL PREFIX (EACH CORRECTIVE ACTION SHO		SHOULD BE COMPL
F 641	Continued From page 23 Nurse and the Wound Nurse would report and document patient information accurately.		F 64	41	
F 732	6/13/19 at 11:02 am s wounds are arterial w #19 was seen by a Va assessment of the wo the Physician had do Resident #19's wound note. Posted Nurse Staffing	-	F 73	32	7/8/19
SS=B	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.				
	specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readab	ost the nurse staffing data h (g)(1) of this section on a inning of each shift. ted as follows: le format. ace readily accessible to			

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### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 732 Continued From page 24 F 732 §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 observations and staff interviews the ADDRESS HOW CORRECTIVE facility failed to post current census and nursing ACTIONS WILL BE ACCOMPLISHED staff data for reviewed posted staffing dated from FOR THOSE RESIDENTS FOUND TO 05/11/2019 through 06/13/2019. HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE. Findings included: No residents were directly affected. The On 06/10/2019 at 10:49 AM A form titled Report Staffing Coordinator and all Nurse of Nursing Staff Directly Responsible for Resident Managers will be re-educated by July 8, Care dated 06/10/2019 and observed posted in 2019 as to the proper posting and the entrance lobby of the facility revealed the maintaining daily staffing hours and facility census listed for the entire date of proper retention of posted daily nurse 06/10/2019 was 93 residents. The facility staffing data for a minimum of 18 months. administrator had confirmed on entrance to the facility that the resident census was 90. The ADDRESS HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING direct care nurse staff was posted for the entire day that included licensed nurses and nurse THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE. assistants (NAs) scheduled to work on the day shift (7:00 AM- 3:00PM), evening shift (3:00 PM -11:00PM) and the night shift (11:00Pm - 7:00 No residents were directly affected. The AM). The facility census number was not Staffing Coordinator and all Nurse changed or updated during frequent observations Managers will be re-educated by July 8, of said form for the day (until 4:00PM). 2019 as to the proper posting and maintaining daily staffing hours and A review of the form titled Report of Nursing Staff proper retention of posted daily nurse

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				CONSTRUCTION		<u>). 0938-03</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345066	B. WING		06	/13/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			4	748 OLD SALISBURY ROAD		
ALSTON E	BROOK		L	EXINGTON, NC 27295		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 732	Continued From page	25	F 732			
1 102	Directly Responsible	for Resident Care dated	1752	staffing data for a minimum of	18 months.	
	from 05/11/2019 through 06/13/2019 revealed that the from was completed daily and that there			ADDRESS WHAT MEASURE		
		de to reflect the exact facility		PUT INTO PLACE OR SYSTE		
		there were any census		CHANGES MADE TO ENSUR		
		4 hour day posted and the		THE DEFICIENT PRACTICE		
		changes in the nurse staffing		RECUR.		
		changed during the 24 hour				
		ay. The forms reviewed		The facility has created a new		
	revealed that nurse s	taff worked form 7:00AM -		Nursing Staff Hours/Census R	eport which	
		1:00 PM, 7:00PM - 7:00 AM		includes, facility name, current		
		V on both Saturdays and		number and the actual hours v	-	
	Sundays.			the following categories of lice		
	On 06/12/2010 at 0.5	0 AM on interview was		unlicensed nursing staff direct	-	
		9 AM an interview was cility Personnel Manager		responsible for resident care p Registered nurses, LPN's, CN		
		ed that she was responsible		Resident census. The form is I		
		master schedule of nurse		down into each shift. The first		
	-	numbers may have been		is the responsibility of the Staf		
		ased on census number and		Coordinator or designee, seco		
		PM revealed that when she		shift posting is the responsibili		
	came to work on wee	kday mornings she received		Nurse Manager or designee. T	he	
	the current facility cer	nsus number from the		weekend shifts posting is the		
	medical record perso			responsibility of the Nurse Mar	nager or	
		he PM placed that census		designee.		
		itled Report of Nursing Staff				
		for Resident Care and then		INDICATE HOW THE FACILIT	-	
		mbers for each shift as they		TO MONITOR ITS PERFORM		
		ter schedule. The PM not change the facility		MAKE SURE THAT SOLUTIO SUSTAINED.	NS ARE	
		<b>u</b>				
	resident census number as the census number changed throughout the day and only posted any			The Director of Nursing or her	Designee is	
	change in resident census on the posted form the			responsible to ensure that the	•	
	next morning. The PM revealed that the licensed			Nursing Staff Hours/Census R	•	
	nurse weekend supervisor did the same on the			posted on a daily basis and pro		
		evealed that she was not		updated each shift. In addition		
		nt census needed to be		proper retention of posted dail		
	changed at the time or shift that the census			staffing data for a minimum of		
	changed. The PM als	o revealed that she did		The Director of Nursing or her	Designee	

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## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 345066 B. WING 06/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 732 Continued From page 26 F 732 change the nurse staff numbers as often as she will complete an Alston Brook Staffing and was able and that she did not save the previously Census QA to ensure compliance as posted form, she printed the staff changes and follows: replaced the form posted in the lobby and 1. Review the Daily Nursing Staff shredded the original form. The PM was unable Hours/Census Report randomly 3 days a to verify that either she or the weekend nurse week for 4 weeks: then updated the form that was posted to reflect the 2. Review the Daily Nursing Staff current facility census or nurse staffing present in Hours/Census Report randomly 3 days a the facility at any time and that she was not week bi-weekly for 4 weeks; then informed that the form was required to show any 3. Review the Daily Nursing Staff Hours/Census Report randomly 5 times changes in census or nurse staffing and that it was to be updated at any time during a 24 hour monthly until resolved by the Quality day. Assurance Committee. On 06/13/2019 at 11:22 AM an interview was On a quarterly basis the Director of conducted with the Director of Nurses (DON). Nursing will present the Quality Assurance The DON revealed that her expectation was that Forms to the Quality Assurance the posted staff form in the facility front lobby be Committee for monitoring and updated to reflect nurse staff present and the recommended changes. correct facility census at any time during the day. The DON revealed the form needed to reflect INCLUDE DATES WHEN CORRECTIVE these numbers in real time at any time. ACTION WILL BE COMPLETED. All re-education and new tracking system will be put into place by July 8, 2019.

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