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¢ -	-	se evidenced by:	This Rule is not met.	
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	522 G	(d) Health Care	10A NCAC 13F .0902	672 Q
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			1	thods not PCP for about		
				With a PCP on 04/26/23 at	Telephone Interview 4:55pm revealed:	
				s ben en smit test ent red		
				ise he would not lock his tried to transfer from or to the Je.	He nad railen becar wheelchair when he bed or tollet commo	
		· .			-He had an x-ray a c	
		· .		ppointment a couple of days mber the type of appointment		
				mq31.4 16 52/32/40 no 1# 1ne	revealed;	
				t to see if Resident #1 had t to see if a refenal was		
				y had multiple fails which had	ever 22/10/20 betab resident #1 recent resulted in hospitalizer	
		loc of the	ð l	care physician (PCP) note	injuries. Review of a primary	4
and		trowny of the sold		sam with no reported injuries. Turwitnessed fail in the st 9:15pm with no reported	-Resident #1 had an	
82/0/5		XUNN		con niw mg 24:8 st 6:45 pm with no unwinessed fall in his room	reported injuries.	
				ant ni list bessentiwin i	You to a head had an	
				moot an ni list bessentiwnu i	reported injuries. -Resident#1 had ar	
				ning to somplaints of pain. I unwitnessed fail in the 23 at 1:21 pm with no	IS DEN F#INSDISSA-	
		DEFICIENCY	£22 g	je j	Confinued From page	ยะเวิด
DVIE COWHFEIE (X2)	38 01	Pario of Corrections of Corrections (Fach Correctione Action Short) (Fach Correctioned To The Action (Fach Correction)	TAG PREFIX ID	TRATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL (SY CIDENTIFYING INFORMATION)	(EVCH DELICIEN	CL (X4) ID XHEFIX YAG (X4) ID
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ibiteled E SNBAEA		NOTTOURTEN		URACOT DEVICERSUPPLIENCLA DEVITIFICATION NUMBER:	от Неайн Сегијов Red гог репојексјеs ог соякестном	TNEMETATS
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,	· .		ANDEX 13F. 125 Separation of Accidents and A	
		D 421	ACO 13F .1212(s) Reporting of Accidents / Incidents	902 701 197 0
-	· .		eldianoged for the Responsible son on 04/26/23 at 11:12am was uccessful.	leal
-			at the KZ6/Z6/20 at the Kaministrator on 04/Z6/Z3 at the magnetic share and 5:40pm revealed she was not sure if a order for neurology and she was have for Several for the severation of a sev	90 OL 9
	All all		srview with the Executive Director on 04/26/23 L35pm revealed she was not aware of a trology referral for Resident #1.	at a Bint
E2/15/5	4 375 350Ald		le need for a neurology consult was discussed to PCP note on 03/01/23 but she did not isider that a true orden, however, there was an er was written on 03/10/23. Is was not aware if the neurology appointment is scheduled for Resident #1.	492- 010 000
201	Horn 1204 4 335		•	15- 12-
	•		ie had given the facility a referral for Resident on 03/10/23 to see a neurologist. ne had not seen where an appointment was de for Resident#1 to see the neurologist.	IS- I#
	•		e month. ssident #1 had multiple falls in February 2023: "17/23, 02/12/23,02/17/23, 02/20/23 and "27/23.	020
	·	D 273	S speq mora beunin	D 573 Co
COMPLETE COMPLETE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY	ID PREFIX IAG	Sammery Strement of Deficiencies (Hoeficiency Wust be Preceded by Full (Motianarchieving Information) (Hoeficiency or Lec Identifying Information)	TAG PREFIX DI (X4) ID
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				ider, guardian/responsible	alth Service Regulation	AH to polaivid
		А 3	ļļ	xecutive director, physician,	care coordinator, e	
				t be made to the supervisor,		
				and call 911 (EMS/Authorities).		
		· ·		stall require immediate		
		-		ich escalates to a threat to the	rw stoivened ynA-	
					date) revealed:	
				ty's Guidelines for Supervision Exhibit Difficult Behaviors (no		
				t #2's Resident Register sion date of 03/28/23.		•
				· •	device.	
				avitiziese suoritiw vioteiudme	-The resident was	
				of care was the special care	-The current level	
		<b>\</b>			regimenti sew eH-	ļ
		Ň			-Diagnosis included	
		4		t#2's current FL-2 dated		
2/16/4		27478 204 350010		<u>.</u> `	The findings are:	
2 July		10			laceration (skin tea	
5		<b>k</b> .		(#2) who was sent to the ER) for evaluation of a		
		the		al services (DSS) for 1 of 3		
		wany st		ity facility to notify the local	interviews, the facil	
			1	ous, record reviews, and		
		1.13.		tyd beonebive as te	m ton si ⊛lu8 sid⊺.	
		X ·	- ·		other than first aid.	
			1.	ization, or medical treatment		
		· ·		eferral for emergency medical resulting in injury to a		
				resident death or any		
				al services of any accident or	department of socia	
	•	•		. Vinuco srli vilion llistis smo	n anso tiubs nA (s)	
			D 481	ge 3	Continued From pa	1970
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56/2023	/\$0		DRESS, CITY, STAT	6909201AH	70/1052 OF 30/101	
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LETED SURVEY	ETAC (EX)	ONSTRUCTION	ע אורטואפ: עא אחרגוארב כ	(X) PROVIDERIZERIALIA IDENTIFICATION NUMBER:	F CORRECTION	TNEMETATE
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			325 326	noitaluas ta	Division of Heal
			T.	provider (MH), and the family were notified.	
		*		-The Resident Care Coordinator (RCC), the primary care provider (PCP), the mental health	
	•			.mq03:7	
				eye. -Resident#2 was sent to the ER for management and evaluation of the injury on 04/19/23 at	
				#S in the eye resulting in a skin tear above the laft	
				and works him to and their resident hit Resident	
				-The incident occurred on 04/19/23 at 7.15mm. -Resident #2 went into another resident's room	
		- - - -		dated 04/19/23 revealed:	
				the provide the second state of the second sta	
				common area and the adjoining dining area.	
				of the facility on 04/25/23 at 9:35am revealed the resident was walking up and down the hall, the	
				Topi leitini ant guring the tradice of Residence of Residence of Residence of Residence of the tradice of the t	
		Ŋ		The resident was hostile frequently.	
		a)(	א ( <i>ו</i>	-The resident was contused, had poor memory, and had wandering behaviors.	
		al mo	,	The resident was easily upset.	
E3/16/5		+ varapost 2 35002		Review of Resident #2's monthly summary report dated 04/01/23 revealed:	
6.1		an as		There was a history of agitation.	
		N3 0		mental illness and behaviors.	
		X		health provider. -The resident was receiving medications for	
•		f.		behaviors. The resident had been referred to a mental	
				-The resident had disruptive/socially inappropriate	ii ii
		· · ·		-The resident was physically abusive.	
	•	1		-The resident had wandening behaviors. -The resident was verbally abusive.	
				Care Plan dated 04/20/23 revealed:	
		•		bus triemseese bengis s'S# Inebises to weives	
				party, and local department of social services.	1
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DATE COMPLETE (XS)	38 01	The state of the s	TAG ID ID	STATEMENT STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG PREFIX (X4) ID
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				dian,	residents' legal Guard	
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				ODS and contacting the RCC,	ncident/accident repo	
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					Exective Director (ED	
			1	incident/accident reports.	oder beteidmos ent-	
·				. tpalsava	04/26/23 at 8:14am	· ·
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				'Inisseoor	isun sew meso.rr 16	
				ne Supervisor on 04/26/23	toH JubA Virugo ent	
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		\ \		interviews with the County	enorigelet betamettA	
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		XG		uter electronic verification or	-There was no como	
52/18/2				the RCC, and the facility	listed as the facility,	
181		N _9		sew rabrias and bris rac	their telephone num	
1841				unty Adult Home Specialist nent of social services and	nas en sool (SHA)	
		. Nº 10 1		Incident report, the recipient	SEW 139[dus 9ni pris	
		X		TOE 00:0 16 22/02/20 at 9:00 EDT.	, sesq ant to got ant	
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		•		l services was notified.	BIOOS 10 MIAUD IEdan	
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					nt out for medical treatment.	If the resident was ser	
					offs were submitted to DSS	-Incident/accident rep	
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					he RCC, ED, PCP and the	t betostroo cAM enT-	
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			There are county	;		to DSS	
			A	1	reports of injuries, abuse or physical altercations		
					-She had submitted the incidents/accidents		
					-DSS was contacted only if they were the resident's legal Guardian.		
					edit enew vedit il vinc		
			÷ •	· · ·		Member,	1
					nd the residents' family by the residents' family	in G.79 ant politicition	
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## PAGAE 10F2

## In reference to rule 10A NCAC 13F.0902(b):

The administrator immediately called to have any orders completed by the primary care physician since she started at the facility be resent over to confirm all orders were in the building. The administrator went over the proper steps with the RCC of how to immediately within 24hours start an order once date the resident was seen and if any new orders were made. So, there is no delay in the resident's care while waiting for the primary care provider to complete their note and send it to the facility. The administrator has now assigned one designee the resident care coordinator to work with the primary care physician whenever they come to the facility or if RCC is not available the administrator/administrator assistant will be present to work with the primary care provider from the beginning of the visits with the residents, going over any needs, to going over visit with any new recommendations made and documented on a physician order sheet.

sheet that all steps are completed and sign off on the sheet that it was verified completed. administrator/administrator assistant will follow up within the week of receiving the new order system resident went to the appointment and any recommendations that were made. The recommendations. The resident care coordinator is to follow the book and document the note that the will fill in the transportation book with the next appointment or note that the resident was seen and any administration assistant to verify that the resident has been taken to an appointment. The transporter coordinator must send copies of schedules for appointments every week to the administrator/ transportation to ensure all referrals have been made and appointments scheduled. The resident care completing any orders, labs, or referrals. The resident care coordinator shall meet weekly with facility bne gnitnemeldmi to steps off gniworls receiving the order showing the steps of implementing and care coordinator must now go through the new order system and be reported to the administrator/ per NC State rules and regulations. All referrals and orders received by the medication aide and resident being trained in the correct and proper way to ensure all residents receive all needed medical attention 5/17/2023, the current Special Care Unit Director has been relieved of duties. A new SCUD is currently up. to ensure the resident's acute and routine health care needs are being met. (05/23/2023) As of An outsourced RN consulting agency was hired to complete training on health care referrals and follow-

## In reference to rule area 10A NCAC 13F. 1212(a):

The facility contracted an outside RN consulting agency to provide in-service staff on completing and reporting incidents/ accident reports. (05/23/2023) The resident care coordinator will now notify the administratory administrator assistant on every accident, incident report by attaching the mow notify the when sent to the adult home specialist by request of the adult home specialist instead of faxing within to administrator/admin assistant and adult home specialist and calling the administrator/admin assistant and adult home specialist (and calling the administrator/admin document the report that was abused, elopement, neglect then will complete the report immediately to administrator/admin assistant immediately upon discovery of the adult home specialist and administrator/admin document the report that was emailed to the adult home specialist and administrator/admin assistant immediately upon discovery of the adult home specialist and administrator/admin document the report that was emailed to the adult home specialist and administrator/administrator assistant with the date and time. SCUD will document each time she sends an accident/ incident report and to the administrator/administrator assistant with the resident care coordinator will be done to assistant with the date and time. SCUD will document the resident status and adult home specialist and administrator and adult home specialist and adult home specialist and administrator and what will be done to to the admin team and adult home specialist and document the resident status and what will be done to to the admin team and adult home specialist and document the resident status and what will be done to to the admin team and adult home specialist and document the resident status and what we hould now what was sent to the administrator follow-

## PAGE 2042

follow up that the needs of the resident were met and what the status/plan is for follow-up with the resident care coordinator within 24 hours of receiving the report on the resident's status.