#### Amended

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICA & MEDICAID SERVICES

PRINTED: 06/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES A CORRECTION	F	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 20		CONSTRUCTION	(X3) DATE	SURVEY
CORRECTION		345152	B. WING _		-	A STATE OF THE STA	C <b>30/2013</b>
NAME OF PRO	VIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 265 21 ST NE IICKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
SS=B To a state of the state of	In the facility, and not resident from the facilischarge is necessared the resident's netactive.  The transfer or discharge the resident sufficiently so the resident sufficiently so the resident services provided by The safety of individing a condition of the safety of individing the services provided by The safety of individing the services provided by The resident has failed appropriate notice, to under Medicare or Medicare or Medicare or Medicare admissional surrounder facility. For a resident mursing facility may contain the facility ceases to the facilities when the residing in dually certain the resident the resident the resident the resident the residing in dually certain the resident the resident the resident the residing in dually certain the resident	mit each resident to remain t transfer or discharge the illity unless the transfer or ary for the resident's welfare eds cannot be met in the earge is appropriate the health has improved sident no longer needs the the facility;  uals in the facility  uals in the facility  endangered;  ed, after reasonable and pay for (or to have paid ledicaid) a stay at the ledicaid) a stay at the ledicaid and serious and serious and serious facility, the sharge a resident only operate.	F		accomplished for each resident found affected by the deficient practice as liste 2567. Specify in detail the corrective act will be accomplished, include dates of complished accomplished, include dates of comportants and the facilities were offer opportunity to return to the facility admission Director on June 18, 201 remaining residents identified in the have either been discharged home expired.  Address how corrective action accomplished for those residents have practice. Specify in detail the process the will utilize in identifying those residents a how the process will be implemented to the residents in similar situations. Use including dates of correction.  Beginning June 21, 2013, the Records Director will randomly revenue.	ed in the tion that rection.  To were ered the by the 3. The survey or have will be aving a deficient e facility and then o protect e details  Medical iew 3 esidents beds on pefore a issued. only be ble for	

Marcheta Campbell

Administrator

MMH

128/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting proving 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.

DEFICIENCIES AND PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CORRECTION	V	245452	B. WNG		С	
		345152	B. WING		05/30/2013	
TRINITY \	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  1265 21 ST NE  HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 201	#7, #8, #10 and #11.  The findings  included:  1. Resident #7 was a for rehabilitation on 0 diagnoses included a hypotension, obstruct history of thrombosis  Social work notes da stated in part "Residinitials) for ST (short home with spouse up therapy." and "Spous apply for Medicaid if 20 days."  Review of care confeat 10:45 AM revealed make progress in the home with his wife. Odated 09/20/12 at 10:43 AM team discussed with they recommended 2 care and that the fam discharge planning for Resident #7's family 10/04/12 that Medica 10/09/12. Additional notice was that the repotential and would conditional in the resident and would be resident and would be resident and would	admitted to the facility 08/29/12. His asthma, dementia, ctive sleep apnea, and a structure sleep apnea, and sleep	F 20 <sup>2</sup>	Address what measures will be put into systemic changes made to ensure deficient practice will not occur.  Effective June 28, 2013, the Add Director will provide additional inform the admission packet to include a staindicating residents may remain in the for necessary skilled care and service their Medicare benefits have been exhausted, the resident may be character will include a statement noting a resident chooses to remain in the room after Medicare benefits have exhausted, the resident may be character and the private room rate. Other the resident will be moved to a semi room in the facility if one is available semi-private room is not available resident may remain in the private resident may remain in the private resident may remain in the private resident as available.  Further, all admissions, discharge, and therapy staff will be instructed of changes and that residents are to be the opportunity to remain in the facility require continued skilled regardless of payer source. Implementally begin immediately and all applicate to be instructed of these changes June 28, 2013.	mission ation in atement e facility es after austed. mission g that if private e been ged the er diem nerwise, -private le, If a le, the eoom at e room nursing of these offered lity if care, entation	

STATEMENT DEFICIENCIE CORRECTION	S AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(92.1%		CONSTRUCTION	(X3) DATE	SURVEY
		345152	B. WING				С
		040102	D. WING			05/	30/2013
TRINITY V	ROVIDER OR SUPPLIER			1:	EET ADDRESS, CITY, STATE, ZIP CODE 265 21 ST NE IICKORY, NC 28601		
(X4) ID PREFIX TAG		FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING	PREFIX CORRECTIVE ACTION SHOULD BE C TAG REFERENCED TO THE APPROPRI DEFICIENCY)		PROVIDER'S PLAN OF CORRECTION (EAG CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 201	that you no longer not by this (the rest of the was also noted that it discharged to another. Per discharge planning Resident #7 was discussed another nursing home physical therapy instance Interview with the Add Director (AMD) on 05 she was responsible the FL2s, doing the assetting up the first cassisted in discharging designated short term facility. The AMD stance beds in the facility was medicare and Medicare and Medicare and Medicare and Medicare and term care residents, explained to resident facility designated be if the resident chose she would try to get the term side or assist in nursing facility for lon notified that a resider discharge from the dearea, she would beging families with transfers to home.  She stated that for an continued nursing call.	has improved sufficiently so seed the services provided e sentence is missing). It Resident #7 was being er long term care facility.  Ing notes dated 10/10/12 to evith follow up ructions.  Inissions and Marketing 6/30/13 at 1:09 PM revealed for all admissions, reviewing admission paper work and re plan meeting. She also and replan meeting. She also are recertified for both aid benefits. She further thad 32 beds allotted for the remainder were for long. The AMD stated that she is and families how the dis upon admission and that for needed to stay long term, them in the designated long placement to another g term care. Once she was at would be ready for esignated short term rehab in to assist residents and so, placements or discharges and there were no beds anated long term area, she	F	201	Indicate how the facility plans to more measures to make sure that solution sustained. The facility must develop, a ensuring that corrections are achieved sustained. The plan must be implement the corrective action evaluated effectiveness. The POC must integrate QAPI system of the facility. Include date corrective action will be complete. Spetthe plan will be integrated into the QA system of the plan will be integrated into the QA system of the plan will be integrated into the QA system of the plan will be integrated into the QA system of the plan will be integrated into the QA system of the plan will be integrated into the QA system of the plan will of 3 resident charts conducted and transfers weekly from onth. An audit of 3 resident charts conducted monthly for 3 months quarterly for 6 months. The facility extend quarterly audits if concertice identified with the audits as listed about the Medical Records Director or Records Assistant will report to the committee each quarter on the committee each quarter on the committee each quarter on the committee admission packet as prementioned.  Effective June 28, 2013, the plan will in the admission packet as prementioned.  By Additional and amended information and the admission packet as prementioned.  By All discharges and transfers and transfers and the quarterly QAPI meeting Medical Records Assistant, with a given at the quarterly QAPI meeting Medical Records Director will be respected in the plan will be	ons are plan for its ded and for its into the es when cify how stem.  In ed the Medical resident for one will be so, then lity will not are ve.  Medical pliance ion in viously will be nonthly ctor or reporting. The onsible	

STATEMENT DEFICIENCIE CORRECTION	S AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	25 - 1000 0000000000000000000000000000000	PLE CONSTRUCTION  G	(X3) DATE COMP	SURVEY
		345152	B. WING _			C <b>30/2013</b>
NAME OF PR	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 1265 21 ST NE HICKORY, NC 28601		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)	SS-	(X5) COMPLETION DATE
F 201	ever stayed in the sh Medicare benefits er Resident #7's family 05/30/13 at 2:34 PM #7 was transferred to she was told this fact after he completed refurther stated it would preference for Resident #7 to stay anot an option.  Follow up interview was:49 PM revealed the Resident #7's family to remain in this facilino bed available on the resident transferred transferred with the Act 4:35 PM revealed the facility, the previous designated the short term care sections, were dually certified Medicaid but she was could not designate to 2. Resident #10 was 04/23/13. Her diagn hypertension, diabet disorder, anemia, and disease.	the AMD, no resident nort term area once nded.  was interviewed by phone on Family stated that Resident of another facility because ility had no available bed ehabilitation. Family district have been her at this facility but that was with the AMD on 05/30/13 at ele AMD was aware that preferred for the resident lity but because there was the long term care area, red to another facility.  Imministrator on 05/30/13 at at when she came to the administrator had already term rehab and the long She further stated all beds for Medicare and is unaware the facility the beds differently.  Is admitted to the facility on oses included dementia, es, asthma, aortic valve diesophageal reflux  atted 04/23/13 at 5:38 PM ent admitted for ST	F 2	c) The plan will be evaluated by the committee to identify potential probled discharges and transfers, and will corrective action and follow up in manner.  d) The plan has been implemented June 19, 2013 and will be requarterly.	ems with suggest a timely	

STATEMENT DEFICIENCIE CORRECTIO	ES AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CORRECTIO	IN.	345152	8. WNG			C 05/30/2013	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	00.	73072013
TRINITY	VILLAGE	-		1265 21 ST NE HICKORY, NC 28601			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 201	Continued From pag	re 4	F	201	1		
F 201	Resident #10's famili 05/24/13 that Medica 05/26/13. Additiona the notice by the Bus (BOM) stated the residecided "she needs has decided to disch Monday 5-27-13 for long term understands." This was being discussed with the side Admissions and Mar Review of the Notice 05/22/13 stated Residischarged from the reason "Your health that you no longer needs to the the side to (name of facility) wontinue skilled occurrence of the capitulation of 10:30 AM, Resident facility for supportive rehab due to diagnos (name of nursing facility was responsible reviewing the FL2s, of the state of the capitulation of the side to the side to diagnos (name of nursing facility was responsible reviewing the FL2s, of the state of the side to the side to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagnos (name of nursing facility for supportive rehab due to diagno	y signed receipt of notice on are benefits were ending I information hand written on siness Office Manager sident and her family had a long term placement and targe to another facility in placement. Son was noted as on, BOM and the keting Director (AMD).  To f Transfer/Discharge dated ident #10 was being facility on 05/22/13 for the has improved sufficiently so seed the services provided e sentence is missing)." It Resident #10 was being er long term care facility.  Thotas dated 05/24/13 at 1:52 and was to be discharged with recommendation to inpational therapy.  To stay, dated 05/27/13 at #10 was "admitted to nursing services and sis. Resident discharged to ility) Date 05/27/2013."  To sissions and Marketing 5/30/13 at 1:09 PM revealed	F	201			

STATEMENT OF DEFICIENCIES AND PLAN OF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
CORRECTION	A	345152	B. WING				C /30/2013
NAME OF PR	ROVIDER OR SUPPLIER		1.	13	EET ADDRESS, CITY, STATE, ZIP CODE 265 21 ST NE IICKORY, NC 28601	0	130/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EAR CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 201	facility. The AMD stabeds in the facility we Medicare and Medic explained the facility short term rehab and term care residents. explained to resident facility designated be if the resident chose she would try to get term side or assist in nursing facility for lon notified that a reside discharge from the darea, she would beg families with transfer to home. She stated that for a continued nursing cavailable on the designate assisted them in nursing facility. According the resident ever stayed once Medicare benefits to make the continued nursing facility assisted them in nursing facility. According the resident #10's family telephone on 05/30/stated he was inform Resident #10 had professional make the sident #10 had professional make the side	m rehab section of the ated all the nursing home ere certified for both aid benefits. She further had 32 beds allotted for d the remainder were for long. The AMD stated that she its and families how the eds upon admission and that or needed to stay long term, them in the designated long a placement to another agiterm care. Once she was not would be ready for resignated short term rehab in to assist residents and is, placements or discharges any resident who needed are, if there were no beds in the short term area, transferring to another ording to the AMD, no in the short term area fits ended.	F	201			
	another long term ca told the facility had n facility but they had o further stated that he Resident	nave to take her home or to re facility. He stated he was o Medicaid bed at this one at their sister facility. He would have preferred for cility as it was closer to					

STATEMENT OFFICIENCIE	S AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	557	345152	B. WING_			C 05/30/2013	
NAME OF PR	OVIDER OR SUPPLIER			12	EET ADDRESS, CITY, STATE, ZIP CODE 265 21 ST NE ICKORY, NC 28601		
(X4) ID PREFIX TAG		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EA CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 201	another nursing facili preparing to discharge there was no long terms the facility. Per the fremaining Medicare could transition from term resident at the runterview with the Add 1:35 PM revealed the facility, the previous designated the short long term care section beds were dually cerm dedicaid but she was could not designate to 3. Resident #8 was for rehabilitation on 0 included a clavicle fracture, femur fracture, femur fracture, femur fracture, femur fracture, stated in part "Reside term) rehab and will assisted living center Resident #8's family 05/14/13 that Medica 05/02/13. Additional on the notice stated to discussed discharge term placement with was available now are discharged to a skille Medicare A benefits stated to discusse of the stated to a skille Medicare A benefits at the stated to a skille Medicare A benefits at the stated to a skille Medicare A benefits at the stated to a skille Medicare A benefits at the stated to a skille Medicare A benefits at the stated to a skille A	esident #10 transferred to ity because she was ge from therapy and rm care bed available at AMD she transferred with benefits so that she therapy to being a long new facility.  Iministrator on 05/30/13 at at when she came to the administrator had already term rehab area and the ons. She further stated all tiffed for Medicare and s unaware the facility the beds differently.  admitted to the facility 03/06/13. Her diagnoses acture, humerus are, and dysphagia.  dated 03/27/13 at 5:19 PM ent admitted for St (short return to (name of	F	201			

	S AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
CORRECTION	1	345152	B. WING			1	C /30/2013
NAME OF PE	OVIDER OR SUPPLIER	<u> </u>		13	EET ADDRESS, CITY, STATE, ZIP CODE 265 21 ST NE ICKORY, NC 28601		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREF TAG	- 2	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROS REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 201	o5/02/13 at 3:20 PM to be discharged to a care. Required assist and continued to be upper extremity.  Review of the Notice dated 05/03/13 reveal discharged from the reason "Your health that you no longer not by this (the rest of the was also noted that I discharged to another the capitulation of st 7:49 AM stated the reacility for supportive due to diagnosis discharged 05/03/13.  Interview with the Ad Director (AMD) on 05 she was responsible the FL2s, doing the assisted in discharging designated short term facility. The AMD stated in the facility we Medicare and Medica explained the facility short term rehab and	arge planning notes dated revealed the resident was another facility for long term stance for all self care tasks non weight bearing to left of Transfer /Discharge aled Resident #8 was being facility on 05/03/13 for the has improved sufficiently so sed the services provided e sentence is missing)." It Resident #8 was being er long term care facility.  ay note dated 05/03/13 at resident was admitted to the nursing services and rehab and the resident was missions and Marketing 5/30/13 at 1:09 PM revealed for all admissions, reviewing admission paper work and re plan meeting. She also ng residents from the n rehab section of the ted all the nursing home	F	201			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345152	B. WING_			C 05/30/2013	
TRINITY \	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 1265 21 ST NE HICKORY, NC 28601	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING	ID PREFI TAG		SHOULD BE CROSS HE APPROPRIATE		
F 201	chose or needed to try to get them in the or assist in placement for long term care. Or resident would be redesignated short terbegin to assist resident transfers, placement She stated that for a continued nursing cavailable on the designated them in transfers them in transfers them in transfers them in the facility. According to stayed in the short the benefits ended.  Follow up interview 3:50 PM revealed R progressing in there and because there withedesignated long term agreed to move her facility.  Interview with the Addissignated the short long term care section beds were dually ceen Medicaid but she was could not designated particular tempted par	on and that if the resident stay long term, she would be designated long term side ent to another nursing facility. Once she was notified that a pady for discharge from the rm rehab area, she would lents and families with the or discharges to home. If there were no beds are, if the another nursing to the AMD, no resident ever term area once Medicare.  With the AMD on 05/30/13 at the esident #8 was not py. The family was called was no bed available in the care area, the family to another skilled nursing the administrator on 05/30/13 at at when she came to the administrator had already at term rehab area and the ons. She further stated all riffied for Medicare and as unaware the facility	F	201			

NAME OF PROVIDER OR SUPPLIER  TRINITY VILLAGE  STREET ADDRESS, CITY, STATE, ZIP CODE  1265 21 ST NE  HICKORY, NC 28601  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES  ID PROVIDER'S PLAN OF CORRECTION (EACH (X5))	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION  NG	l(X	(X3) DATE SURVEY COMPLETED C	
TRINITY VILLAGE.    269 ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY AUST SEP PRECEDED BY FULL TAG)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY AUST SEP PRECEDED BY FULL TAG)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION (EACH CORREC			345152	B. WNG_		-	ranco areas Provincios
PREFIX TAG  REGULATORY OR ISG IDENTIFYING NATION)  F 201  Continued From page 9 a recent stroke and fractured femur.  Social service notes dated 04/10/13 at 9:35 AM stated in part "Resident admitted for ST (short term) Rehab and will return home."  Social service notes dated 05/24/13 at 10:30 AM stated the facility called to speak with the responsible party regarding long term care placement. The responsible party was noted to be in agreement and resident will move 05/28/13.  Rosident #11's responsible party signed recelpt of notice on 05/27/13 that Medicare benefits were ending 05/27/13. Additional information hand written on the notice stated on 05/24/13 the Admissions and Marketing Director (AMD) talked with the resident's son and explained the long term care bed availability at the isster facility. The note stated the son requested the resident be transferred to the sister facility on 05/28/13 to continue Med A (reatment and transitioning to long term care.  Discharge Planning notes dated 05/27/13 at 6:31 PM indicated Resident #11 was nonweight bearing through lower extremity. Resident needed support for safety with transfers and should not walk because he was noncompliant with non weight bearing status. He should continue leg exercises.  The Notice of Transfer/Discharge dated 05/28/13 stated Resident #11 was being					1265 21 ST NE		
a recent stroke and fractured femur.  Social service notes dated 04/10/13 at 9:35 AM stated in part "Resident admitted for ST (short term) Rehab and will return home."  Social service notes dated 05/24/13 at 10:30 AM stated the facility called to speak with the responsible party regarding long term care placement. The responsible party was noted to be in agreement and resident will move 05/28/13.  Resident #11's responsible party signed receipt of notice on 05/27/13 that Medicare benefits were ending 05/27/13. Additional information hand written on the notice stated on 05/24/13 the Admissions and Marketing Director (AMD) talked with the resident's son and explained the long term care bed availability at the sister facility. The note stated the son requested the resident be transferred to the sister facility on 05/28/13 to continue Med A treatment and transitioning to long term care.  Discharge Planning notes dated 05/27/13 at 6:31 PM indicated Resident #11 was nonweight bearing through lower extremity. Resident needed support for safety with transfers and should not walk because he was noncompliant with non weight bearing status. He should confinue leg exercises.  The Notice of Transfer/Discharge dated 05/28/13 stated Resident #11 was being	PREFIX	(EACH DEFICIENC REGULATORY OF	CY MUST BE PRECEDED BY FULL	PREFIX	CORRECTIVE ACTION SHOULD REFERENCED TO THE APPR	BE CROSS-	COMPLETION
reason "Your health has improved sufficiently so that you no longer need the services provided by this (the	F 201	a recent stroke and Social service notes AM stated in part "R (short term) Rehab a Social service notes stated the facility cal responsible party re placement. The res be in agreement and 05/28/13.  Resident #11's resp of notice on 05/27/13 ending 05/27/13. Ac written on the notice Admissions and Mar with the resident's so term care bed availa The note stated the be transferred to the continue Med A trea long term care.  Discharge Planning PM indicated Reside bearing through low needed support for a should not walk beca noncompliant with no He should continue I  The Notice of Transf 05/28/13 stated Res discharged from the reason "Your health that you no	dated 04/10/13 at 9:35 esident admitted for ST and will return home."  dated 05/24/13 at 10:30 AM filed to speak with the garding long term care ponsible party was noted to d resident will move  onsible party signed receipt 3 that Medicare benefits were diditional information hand estated on 05/24/13 the fixeting Director (AMD) talked on and explained the long ability at the sister facility, son requested the resident esister facility on 05/28/13 to timent and transitioning to  notes dated 05/27/13 at 6:31 ent #11 was nonweight er extremity. Resident er extremity. Resident safety with transfers and ause he was on weight bearing status, leg exercises.  fer/Discharge dated ident #11 was being facility on 10/10/12 for the has improved sufficiently so	F2	201		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O		(X3) DATE SURVEY COMPLETED	
		345152	B. WNG		1	30/2013
NAME OF PI	ROVIDER OR SUPPLIER		126	ET ADDRESS, CITY, STATE, ZIP CODE 66 21 ST NE CKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (E CORRECTIVE ACTION SHOULD BE CRO REFERENCED TO THE APPROPRIATI DEFICIENCY)	oss-	(X5) COMPLETION DATE
F 201	The capitulation of a AM stated Resident facility for supportive rehab due to diagnot on 05/28/13.  Interview with the A Director (AMD) on 0 she was responsible the FL2s, doing the setting up the first crassisted in discharge designated short terfacility. The AMD states in the facility with Medicare and	ge 10 ras being discharged n care facility for care.  stay dated 05/28/13 at 7:56 #11 was admitted to the e nursing services and ses and he was discharged  dmissions and Marketing 15/30/13 at 1:09 PM revealed e for all admissions, reviewing admission paper work and are plan meeting. She also ing residents from the m rehab section of the ated all the nursing home tere certified for both eald benefits. She further of had 32 beds allotted for d the remainder were for long The AMD stated that she ts and families how the eds upon admission and that or needed to stay long term, them in the designated long in placement to another ing term care. Once she was int would be ready for lesignated short term rehab in to assist residents and is, placements or discharges  my resident who needed are, if there were no beds gnated long term area, transferring to another ording to the AMD, no	F 201			

	S AND PLAN OF	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
CORRECTION	4				С	
		345152	B. WING		05/30/2013	
NAME OF PR	ROVIDER OR SUPPLIER		120	EET ADDRESS, CITY, STATE, ZIP CODE 65 21 ST NE CKORY, NC 28601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EAC CORRECTIVE ACTION SHOULD BE CROSS REFERÊNCED TO THE APPROPRIATE DEFICIENCY)		
F 201	11 benefits ended.  Follow up interview v 3:49 PM revealed Re discharge home after able to return home. was no available bed in the I so while on Medicare facility to transition to further stated the res expressed anything a facility.  Interview with the Ad 4:35 PM revealed tha facility, the previous a designated the short long term care sectio beds were dually cert Medicaid but she was could not designate the	with the AMD on 05/30/13 at esident #11's intent was to rehab but he was not. The AMD stated there ong term designated area at A he moved to another olong term care. She ident nor the family about remaining in this ministrator on 05/30/13 at at when she came to the administrator had already term rehab area and the ns. She further stated all tified for Medicare and sunaware the facility he beds differently.	F 201			