PRINTED: 04/06/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345410	B. WING _			03/	03/2016
	ROVIDER OR SUPPLIER CONTINUING CARE		•	STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 241 SS=D	manner and in an emenhances each reside full recognition of his This REQUIREMENT by: Based on observation interviews the facility residents ' privacy by drainage bag with a pand 98). The findings included 1. Resident #64 was 3/19/15 with diagnost dementia and dysfun. The Minimum Data Squarterly, indicated Rindwelling urinary cat bladder. The MDS in short and long term in Observations on 03/0 dining room, revealed a geri-chair with a uri to the arm rest on the drainage bag was no There were visitors, of the main dining room Cloudy light yellow ur drainage tubing up to Observations on 03/0 ob	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality. The is not met as evidenced Instantia to protect two of four or not covering a urinary privacy bag. (Residents #64) Examined: admitted to the facility on est including hypertension, ction of the bladder. et (MDS) dated 1/15/16, a resident #64 had an heter and a neurogenic cluded Resident #64 had nemory impairment. 12/16 at 8:23 AM in the main of Resident #64 was sitting in nary drainage bag attached a geri-chair. The urinary to covered with a privacy bag. Other residents and staff in during the observation. The was observed in the	F2	241	1) On 3/2/16, the nurse assigned to Resident #64 located the privacy bag of the side of the resident segri-chair an placed the urinary drainage bag in the privacy bag. On 3/2/16, the Director of Nursing conducted targeted education sessions with staff regarding the neces of covering urinary drainage bags to protect resident privacy. The Director of Nursing also conducted pre-scheduled, monthly nursing department meetings which were held on 3/8/16 and 3/14/16. The topics of mandatory privacy bags, proper placement of catheters on wheelchairs, geri-chairs, and beds were added to agenda as was proper securir of catheter tubing via leg straps. The Director of Nursing and the Staff Development Coordinator scheduled mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, a 3/24/16 to discuss the implementation of Daily Care Guides to serve as an effect reference tool for staff providing daily contents. The meeting agenda addressed several issues including privacy bags for urinary drainage bags,	sity f e ng nd of tive are	3/31/16
	and taken to her roor	n. The urinary drainage bag			leg straps to secure catheter tubing,		
ABORATORY		of the geri-chair with no SUPPLIER REPRESENTATIVE'S SIGNATURE			placement of urinary drainage bags bel		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/24/2016

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.

Electronically Signed

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				12	287 NEWSOME STREET		
CENTRAL	. CONTINUING CARE			M	IOUNT AIRY, NC 27030		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 241	Continued From page	e 1	F	241			
	privacy covering on t				the bladder to prevent infection, the		
					classification and use of restraints, the		
	Observations on 03/0	02/16 at 9:47 AM with NA #6			proper use of all equipment related to		
		64 did not have a privacy			splinting, contracture management, and	d	
	-	drainage bag positioned on			devices used for other purposes like		
the armrest of the ge		ri-chair. NA#6 explained the			prevention of skin breakdown and		
		sitioned on the arm rest due			pressure relief. Upon investigation, it w		
	to not being able to place it anywhere else on the				revealed that there were no privacy bag	gs	
	geri chair.				in the supply closet. The facility supply		
	Intention on 03/03/14	S at 0.50 AM with NA #7			clerk indicated the items had been		
		6 at 9:50 AM with NA #7, : #64) revealed she was not			ordered but were not available from the vendor on 3/2/16. The privacy bags we		
	sure if the resident ha			received from the vendor on Thursday	16		
		A #7 had provided care to			3/3/16 and the need for privacy bags w	as	
		hree weeks ago and she did			determined to be for only one resident,	40	
		vacy bag in use at that time.			#98 at which time, the privacy bag was		
	'	, 3			put into place and the urinary drainage		
	Interview with Nurse	#2 on 100 hall on 03/02/16			bag was placed in it.		
	at 10:05 AM revealed	d the urinary drainage bag			2) On 3/22/16, the facility supply clerl	<	
	-	y cover on the drainage bag.			researched the possibility of other urina	-	
		th Nurse #2, she went to			catheter privacy options. Urinary draina	ige	
		n. Inspection of the urinary			bags with attached privacy flaps were		
	drainage bag by nurs				identified and ordered. The use of this	4-	
		ag was attached on the right			equipment will take the place of separa	ite	
	_	footrest. Nurse #2 removed placed the urinary drainage			privacy bags when available. 3) Daily care guides will be implemen	uted	
	bag in the cover.	Diaced the diffiary drainage			immediately following staff training. A d		
	bag in the cover.				care guide will be generated from	ally	
	Interview with the Dir	rector of Nursing (DON) on			American Health Tech based on the		
		I revealed she would expect			information entered into each individua	ı	
		rivacy cover on the urinary			care plan by the MDS staff. A printed c		
	drainage bag.	-			of each resident□s daily care guide will		
					placed in a clear, protective covering or		
		admitted to the facility			the inside door of each resident□s clos		
	_	ses of neurogenic bladder			Daily care guides will be updated base	d	
	and diabetes.	(4450)			on changes in information, status,		
	The Minimum Data Set (MDS), an admission,				physician orders, and care plan update		
		red Resident #98 had			These changes will be documented by		
	i impaireu short and id	ng term memory, moderate			nurse receiving the information and will	υ υ	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 241	Continued From page	e 2	F 24	1			
F 241	impairment with daily and had an indwelling. Observations on 03/0 Resident #98 was in drainage bag was pobedframe, facing the privacy bag was not bag. Observations of Resident AM revealed a privacy the urinary drainage urine was visible from Observation of Resident was visible from Observation of Resident was not drainage bag. The desident with the hallway. Interview with Nurse 10:55 AM revealed seed the hallway. Interview with Nurse 10:55 AM revealed seed the hallway. Interview with Nurse 10:55 AM revealed seed the hallway. Interview with Nurse 10:55 AM revealed seed the hallway.	decision making abilities gurinary catheter. 21/16 at 8:57 AM revealed her room. The urinary sitioned on the bottom of the open door to the hall. A in place over the drainage dent #98 on 03/02/16 at 8:00 by bag was not used to cover bag. The drainage bag with in the hallway. 2 ent #98 on 03/02/16 at he was in her room and a used to cover the urinary rainage bag was visible from Aide (NA) #8 on 03/02/16 at he provided care for 01/16 and today on 03/02/16. In NA #8 revealed Resident rivacy bag for the urinary explained a privacy bag was erday. During the interview explained she had asked the	F 24	dated and signed appropriately. All currently employed nursing staff wi educated on location and content of care guides. Newly hired staff will be educated on the daily care guide used during the orientation process. New admissions will have a written daily guide based on their initial assessmand physician orders and will be ut until the care plan assessment has completed. 4) The Director of Nursing and the management team met on 3/21/16 discuss necessary changes to ensure privacy bags and leg straps were mandatory. The decision was made add these items to the Treatment Administration Record (TAR). This procedure change will prevent the absence of these necessities from occurring again. Signing off on these items by the treatment staff will be performed daily. 5) The facility urinary drainage capolicy was updated on 3/21/16 to in the mandatory use of leg straps to tubing and privacy bags or flaps for indwelling catheters as well as urindrainage bag placement to be lowed the bladder to prevent infection. 6) Daily care guides, and dignity concerns will be added to the monter.	f daily le se se / care nent lized been e nurse to ure e to se witheter include secure e all ary r than		
	03/02/16 at 10:25 AM	ector of Nursing (DON) on I revealed she would expect rivacy cover on the urinary		nursing department staff meeting a 7) Procedures will be assessed a reviewed at the upcoming quarterly meeting. Chart reviews will continu weekly basis. Noted issues will cor to be remedied immediately by the nurse and ADON. Areas of concern	genda. nd QAA e on a tinue QA		

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F 241	Continued From page	÷ 3	F	241	addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.		
F 278 SS=D	483.20(g) - (j) ASSES ACCURACY/COORD		F:	278			3/31/16
	The assessment must accurately reflect the resident's status.						
	A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.						
		completes a portion of the n and certify the accuracy of sessment.					
	willfully and knowingly false statement in a re subject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material ar	ey penalty of not more than ssment; or an individual who y causes another individual and false statement in a is subject to a civil money					
	Clinical disagreement material and false sta	does not constitute a tement.					

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F 278	Continued From page	e 4	F	278			
	· -	nis REQUIREMENT is not met as evidenced					
	by:	1 13 Hot met as evidencea					
		ons, record review and staff			1) On 3/2/16, the nursing staff was		
		ailed to include the use of a			immediately educated on proper use of	f	
		recent Minimum Data Set			the soft mitt based on the order indicat		
	assessment for one	of one resident with a			its use on the right hand.		
	restraint. (Resident a	4 90).			Upon re-evaluation by the medical		
				director and in the absence of			
	The findings included	i :			documented OCD behaviors, the use of	of	
	D:-	locition day the feedble con-			the soft mitt to the right hand was		
		Imitted to the facility on			discontinued. No areas of skin breakdo		
	_	is including Alzheimer's vith left side weakness.			or rash were present. The soft mitt was utilized as ordered until the	•	
	disease and stroke w	itti lett side weakiless.			discontinuation date on 3/11/16.		
	A telephone order da	ted 12/28/15 indicated a soft			The Director of Nursing and the St	aff	
	-	on the right hand to " protect			Development Coordinator scheduled		
		essive compulsive disorder)			mandatory meetings for all nursing		
	behaviors." Instruc	tions included to " check			department staff on 3/22/16, 3/23/16, a	ınd	
	daily skin. "				3/24/16 to discuss the implementation	of	
					Daily Care Guides to serve as an effect		
		Set (MDS) dated 12/31/15			reference tool for staff providing daily of	are	
		90 had long and short			to residents. The meeting agenda		
		with severe impairment of			addressed several issues including privacy bags for urinary drainage bags		
	daily decision making assessed the resider				leg straps to secure catheter tubing,	,	
		ities of daily living (ADLs).			placement of urinary drainage bags be	low	
		ateral impairment of both			the bladder to prevent infection, the	1011	
		emities with functional			classification and use of restraints, the		
		S did not indicate a physical			proper use of all equipment related to		
	restraint was in use f				splinting, contracture management, an	d	
					devices used for other purposes like		
	-	n update of 1/6/16 included			prevention of skin breakdown and		
		I thought processes and			pressure relief. Education was also		
	limited communication				provided to staff on the difference		
	excessive rubbing he				between a soft mitt and a restraint as v	vell	
		d the use of a soft mitt to the			as other types of restraints. This		
		nt hand and to check the skin under the mitt			information is based on the state ☐s definition of a restraint indicating any		
	daily.				equipment that can hinder an individua	l⊓s	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 278	#90 revealed she was right hand. Observations on 3/2/and 2:30 PM revealed mitt applied to the left. Interview with MDS n AM revealed the soft restraint. The MDS n resident did not have of her right hand. " Interview with the Dire 03/02/16 at 8:56 AM (soft mitt) as a restraint #90 was to wear their behaviors of constant current physician ordewere reviewed with D pose a question. The (soft mitt) was to be use the physician of constants.	/16 at 3:29 PM of Resident in bed with soft mitt on 16 at 8:30 AM, 10:30 AM degree Resident #90 had the soft in hand. 17 at 1 on 03/02/16 at 8:27 mitt was not considered a urse #1 explained the "purposeful movement" 18 ector of Nursing (DON) on revealed she did not see it not. She explained Resident mitt when she displayed in rubbing of her head. The ters and TAR documentation ON and she explained, it did DON added, she thought it is sed as needed for in rubbing of her head.		normal body movement. Staff ed on the expectation to reevaluate question treatments not found, n available, or not effective and where find extra equipment (Clean linest closet located on the 400 hall). To topics will also be added to April monthly nursing department staff 4) For orders on devices or equation that can be defined as restraints clarification will be obtained as we alternate interventions. All orders followed and added to the care produced contains information to che daily, this will be placed on the T signed off on daily. If the interventioned deemed necessary and is defined restraint, appropriate documentate be utilized per state regulations. Order will be added to the MDS assessment and subsequently to care guide. The use of daily care will eliminate unanswered questing the use of any equipment or proplacement of such equipment. 5) Procedures will be assessed reviewed at the upcoming quarted meeting. Chart reviews will continue weekly basis. Noted issues will continue to be remedied immediately by the nurse and ADON. Areas of concaddressed in quarterly committed meetings. All changes to proceed processes will be implemented immediately if necessary. The Administrator is responsible for compliance.	e or not here to n supply These s ff meeting. uipment s, well as s will be plan. If an eck skin TAR and ntion is ed as a ation will Any such to the daily e guides ions about per d and erly QAA inue on a continue he QA ern will be the large or second the continue he per the continue he per the continue he per the continue he cont		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F:	280		3/31/16	

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F 280 SS=D	The resident has the incompetent or other incapacitated under to participate in plannin changes in care and A comprehensive car within 7 days after the comprehensive asses interdisciplinary team physician, a register for the resident, and disciplines as determinand, to the extent pratter the resident, the resident legal representative;	right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment. re plan must be developed	F 2	80			
	This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to update a care plan to include restorative nursing for one of two residents with restorative nursing (Resident #92). The findings included: Resident #92 was admitted to facility on 9/19/11 and readmitted on 9/27/15. The most recent diagnoses included chronic pain, muscle weakness, unspecified lack of coordination and osteoarthritis.			1) On 3/3/16, it was identified Resident #92 had restorative in were not conveyed from the thickness department to the nursing department to the nursing department to the Restorative wrote the recommendations upprestorative flowsheet, educated staff about the current restoration about exercises. The Restorative platimplemented per therapy□s recommendations. 2) The Director of Nursing medical restorative in the staff and provided education about exercises.	needs that erapy artment. e Nurse o on the d the hall ive needs, the types of n was then		

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F 280	Continued From pag	e 7	F 2	280			
I		um Data Set (MDS) dated , indicated Resident #92 had			nursing management staff on 3/21/16 discuss necessary changes to the	to	
		Mental Status (BIMS) of 13			restorative program to guarantee prog	oor	
		and short term memory was			follow through on therapy	JEI	
	_	licated Resident #92 required			recommendations.		
		e of one staff for all activities			 The Director of Nursing conducte 	٦d	
		. Review of the MDS			pre-scheduled, monthly nursing	,u	
	indicated Resident #			department meetings which were held	d on		
	limited functional mo			3/8/16 and 3/14/16. The topic of prope			
		r balance for sitting and			care and completion expectations rela		
	transfer.				to the restorative program was discus		
					The Director of Nursing and the Staff		
	The "Restorative R	eferral " signed by the			Development Coordinator scheduled		
		indicated Restorative care			mandatory meetings for all nursing		
		/15. This form was the			department staff on 3/22/16, 3/23/16,	and	
	-	cation between therapy and			3/24/16 to discuss the implementation		
		The goals included "Patient			Daily Care Guides to serve as an effe		
	will perform towel gli	des on table surface forward			reference tool for staff providing daily	care	
	and back, also, side	to side. 20 reps (repetitions)			to residents. The meeting agenda		
	x (times) 2 sets Righ	t Shoulder. " The program			addressed several issues including		
	included bilateral up	per extremity range of motion			privacy bags for urinary drainage bags	S,	
	to be provided 5 time	es a week.			leg straps to secure catheter tubing,		
					placement of urinary drainage bags be	elow	
	PT referral for Resto	orative care would begin on			the bladder to prevent infection, the		
	12/8/15. The goals i	ncluded " Maintain pt			classification and use of restraints, the	е	
	(patient) current fund	ctional status. Maintain			proper use of all equipment related to	1	
	AROM on BLE (bilate	eral lower extremities) " The			splinting, contracture management, a	nd	
		tient will perform BLE AROM			devices used for other purposes like		
		es 2 times for 20 repetitions.			prevention of skin breakdown and		
		ransfers to and from the			pressure relief. The importance of		
		ling walker with contact			identifying and reporting changes in		
	guard assist.				resident status was also discussed in		
					order to prevent worsening conditions		
		lan updated on 1/13/16			Proper restorative program functions		
		of impaired mobility related to			discussed as well. Each of these type		
		ty. The interventions			care will be listed on the daily care gu		
		efer resident to restorative			Clarifications were offered as to the ty	rpes	
		s reached her max potential			of exercises that were currently		
	for a maintenance pr	ogram. The therapy			recommended for residents and what	ADL	

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F 280	referrals from 11/4/18 included on the care Interview with the MI 10:48 AM revealed s	5 and 12/1/15 were not plan. OS Nurse #1 on 3/3/16 at he had not updated the care inge of motion exercises.	F2	function of more address hall we restor documents flowsh week Nurses 4) 0 Direct Devel need related exercition and the restor determined for all 5) A Programa restor determined for all 5) a particular performation	ons were equivalent to those typotement. It was specifically assed that CNAs assigned to each rere responsible for performing the rative functions as ordered. Proponentation on the restorative neet will serve a proof of compliancy monitoring by the Restorative will take place. In 3/22/16, the Therapy Director, for of Nursing, and the Staff dopment Coordinator discussed the for in-services for the nursing stands to the functional restorative ises, rationale behind the exercise need for consistent movement estorative recommendations. It womined that mandatory in-services to be conducted by the therapy stands as under the conducted as such: worative need has been identified mined by the therapy department accommendation(s) will be conducted on a Restorative Reference and the staff will be educated on ular type of exercises to be med. Copies of the referral form went to the MDS/Care Plan nurses of the Restorative Nurse. The care will be updated. The referral will in up on a restorative flowsheet to esistant Director of Nursing ioning as the Restorative Nurse and the appropriate Restorative designated by each resident hall diditions or changes to daily care ded to the resident sindividual individual individ	the er ance. the he aff ses, t via as saff when or t, ral the will se pe py and l. e will		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030		
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F 282 SS=D	483.20(k)(3)(ii) SERV PERSONS/PER CAR The services provided must be provided by	CICES BY QUALIFIED RE PLAN	F 2	care guide. The hall staff will have acc to the restorative recommendations as each book will be kept on its designate hall. 6) Once the Restorative plan has be written up by the Restorative Nurse, the referral form is placed in the resident medical chart behind the Restorative to the total chart side and to date, running list of residents in nee a restorative plan. This list will be categorized by resident name, start date restorative recommendations and frequency of exercises. A reassessme date will also be scheduled for each resident to evaluate appropriateness at possible continuation of the program. 8) Procedures will be assessed and reviewed at the upcoming quarterly Quarterly. Chart reviews will continue of weekly basis. Noted issues will continue of weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern with addressed in quarterly committee meetings. All changes to procedures of processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	en e s ab. up d of te, nt nd NA n a ne nl be	3/31/16
	accordance with each care.	resident's written plan of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345410	B. WING		03/03/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00:00:20:0
			1	287 NEWSOME STREET	
CENTRAL	CONTINUING CARE			MOUNT AIRY, NC 27030	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 282	, , , , , , , , , , , , , , , , , , ,		F 282		
	by: Based on observation interviews the facility	ns, record reviews and staff failed to follow care plan		The Director of Nursing and the Stone Development Coordinator scheduled	aff
	(Resident #90), one of indwelling urinary cath three residents with P	residents with a restraint of two residents with an heter (Resident #64), one of ressure ulcers (Resident #		mandatory meetings for all nursing department staff on 3/22/16, 3/23/16, a 3/24/16 to discuss the implementation Daily Care Guides to serve as an effect	of tive
	range of motion (Resi	,			
	11/6/12 with diagnosis	s including Alzheimer's ith left side weakness.		leg straps to secure catheter tubing, placement of urinary drainage bags be the bladder to prevent infection, the	
	mitt was to be used o skin from OCD (obser	red 12/28/15 indicated a soft in the right hand to " protect assive compulsive disorder) ion included to " check daily		classification and use of restraints, the proper use of all equipment related to splinting, contracture management, and devices used for other purposes like prevention of skin breakdown and pressure relief.	d
	indicated Resident #9	vith severe impairment of abilities. This MDS		Daily care guides will be implemer immediately following staff training. A care guide will be generated from American Health Tech based on the information entered into each individual	aily
	Resident #90 had bila upper and lower extre	did not indicate a physical		care plan by the MDS staff. A printed confeach resident staily care guide will placed in a clear, protective covering of the inside door of each resident scloss Daily care guides will be updated base	l be n et.
	problems of impaired limited communication excessive rubbing he Interventions included			on changes in information, status, physician orders, and care plan update These changes will be documented by nurse receiving the information and will dated and signed appropriately. All currently employed nursing staff will be educated on location and content of dates.	the be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345410	B. WING			3/03/2016	
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO	•		
				1287 NEWSOME STREET			
CENTRAL	CONTINUING CARE			MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From pag	ge 11	F 28	32			
	daily.	•		care guides. Newly hired sta	iff will be		
				educated on the daily care g			
	The February 2016	monthly orders included the		during the orientation proces			
		n the right hand due to		admissions will have a writte	n daily care		
		ve behavior of rubbing her		guide based on their initial a			
		hand. The skin was to be		and physician orders and wil			
	inspected daily unde	er the mitt.		until the care plan assessme	ent has been		
	Povious of the Treats	ment Administration Record		completed. 3) For orders on devices o	r oquinmont		
		2016 revealed the ordered		that can be defined as restra			
		hand was not applied for 8		clarification will be obtained	•		
		not in room" and "mitten		alternate interventions. All or			
	being washed."			followed and added to the ca	are plan. If an		
	-			order contains information to	check skin		
		29/2016 at 9:45 AM revealed		daily, this will be placed on the			
		g on her right hand. The		signed off on daily. If the inte			
		red using her right hand to		deemed necessary and is de			
	grab ner blanket and	d pull it up to her chest.		restraint, appropriate docum be utilized per state regulation			
	Observation on 3/1/	2016 at 9:00 AM revealed		order will be added to the MI			
		othing on her right hand. The		assessment and subsequent	_		
		red rubbing her head with her		care guide. The use of daily			
	hand in a closed fist	•		will eliminate unanswered qu	-		
				the use of any equipment or	proper		
		01/2016 at 3:29 PM of		placement of such equipmer			
		led she was in bed with soft		4) Staff educated on 3/22/			
	mitt on right hand.			and 3/24/16 about the expec			
	Observations on 2/3	0/2016 at 9:20 AM 10:20 AM		reevaluate or question treatr			
		2/2016 at 8:30 AM, 10:30 AM ed Resident #90 had the soft		found, not available, or not e where to find extra equipmer			
	mitt applied to the le			linen supply closet located o	•		
				hall). These topics will also be			
	Interview with Nurse	e #1 on 03/02/2016 at 9:06		April⊡s monthly nursing dep			
	AM revealed the rig	ht hand mitt was to be applied		meeting.			
		was awake for the most part.		5) The facility urinary drain			
		nitt didn't "stay on well, she is		policy was updated on 3/21/			
		d " Nurse #1 explained the		the mandatory use of leg stra	•		
		tch herself and had repetitive		tubing and privacy bags or fl			
	∣ motions and the mit	t would come off. The		indwelling catheters as well a	as urinary		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345410	B. WING _			03/03/2016	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CO		0.00.2010	
				1287 NEWSOME STREET			
CENTRAL	CONTINUING CARE			MOUNT AIRY, NC 27030			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From page	e 12	F 2	82			
F 282	resident did not remore Further interview revolutions on 03/02 which hand and not the mitt was not put the mitt was on the with the mitt was on the with hand and not the right morning and put the interview with NA#2 or revealed she was not but knew she had a recontinued interview worn all day because and/or rub herself with the mitt was on the with hand and not the right laterview with NA#2 or revealed she was as had not put the mitt or explained night shift of morning and put the interview with NA #2 which hand should have observations on 03/02 revealed the soft mitt not right hand. Resident #90 was in hand and continuous	ealed Resident #90 could not of the right hand. Resident r" type movement of her binch, or grasp without the view Nurse #1 explained she of device for the left hand. In 03/02/2016 at 9:12 AM assigned to Resident #90, mitt for the right hand. The revealed the mitt would be a Resident #90 would scratch that hand. In 03/02/2016 at 10:35 AM with the e therapy manager revealed wrong hand. It was on the left out. In 03/02/2016 at 10:42 AM asigned to Resident #90 but on the resident. NA #2 gets the resident up in the mitt on her. Further revealed she did not know ave the mitt.	F 2	drainage bag placement to be the bladder to prevent infect 6) Pressure relieving device placed on the TAR per standaresidents identified to have a breakdown or potential for silbreakdown. This will be signed the treatment staff every shirt information will also be on the guide. 7) As of 3/23/16 the Resto Program will be conducted as a restorative need has been determined by the therapy of the recommendation(s) will be communicated on a Restoration and the staff will be eduparticular type of exercises the performed. Copies of the refibe given to the MDS/Care Pland to the Restorative Nurse plan will be updated. The refiwritten up on a restorative flow the Assistant Director of Nur (functioning as the Restorative placed in the appropriate Rebook designated by each restorative recommendations or changes to be added to the resident sicare guide. The hall staff will to the restorative recommendations or changes to be added to the Restorative recommendations or changes to be added to the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is placed in the medical chart behind the Restorative referral form is	ion. ces will be ding order for skin kin led off on by ft. This le daily care rative as such: when identified or epartment, be tive Referral lucated on the to be ferral form will lan nurses a. The care ferral will be bwsheet by sing ve Nurse) and estorative sident hall. daily care will individual daily I have access dations as a designated an has been a Nurse, the resident las. estorative tab.		
	hand. Observations on 03/0 Resident #90 was in	02/2016 3:27 PM revealed bed with the mitt on the left		hall. 8) Once the Restorative pl written up by the Restorative referral form is placed in the	an has been e Nurse, the resident□s estorative tab. t will follow up		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345410	B. WING _		03/03/2016
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP C	·
				1287 NEWSOME STREET	
CENTRAL	CONTINUING CARE			MOUNT AIRY, NC 27030	
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLETIC DATE
F 282	Continued From pag		F 2		onto in need of
	revealed she was protoday on 3-11 shift. familiar with the Reswhat to do for the reckept at the nurse's saccess to the care posterior that was need for Resident #90 was would scratch herse contracted hand (left). Observations on 03/Resident #90 did not linterview with NA #4/revealed she had proon 11-7 shift on 3/2/at times. When aske explained the reside herself. When aske the mitt, she explained the resident could open while providing incort the resident did not copened up both hand.	would inform her of anything ded for the resident. The mitt is for her agitation and she if. It was to be applied to her is hand). 03/2016 at 6:55 AM revealed it have a mitt on either hand. on 3/3/16 at 6:55 AM povided care for the resident left. The resident wore a mitt end what it was for she int would rub or scratch on it would rub or scratch on it would require end "it would depend, it could arther interview revealed the both hands. NA#4 explained intinence care this morning, want to be bothered and she intitled to the facility on 3/19/15 ling hypertension, dementia		to date, running list of resid a restorative plan. This list categorized by resident nar restorative recommendation frequency of exercises. And date will also be scheduled resident to evaluate appropossible continuation of the 10) Procedures will be ass reviewed at the upcoming of meeting. Chart reviews will weekly basis. Noted issues to be remedied immediately nurse and ADON. Areas of addressed in quarterly commeetings. All changes to processes will be implement immediately if necessary. The Administrator is responsible compliance.	will be me, start date, ms and eassessment for each criateness and e program. essed and quarterly QAA continue on a will continue y by the QA concern will be mittee cocedures or ited The
	The Minimum Data S quarterly, indicated F indwelling urinary ca	Set (MDS) dated 1/15/2016, a			

STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345410	B. WING		03/03/2016	
NAME OF PROVIDE				STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 282 Con	inued From paલ્	ge 14	F 28	32		
prob goal inter UTI, pullii intak char Obs dinir a ge to the drair in the Obs Resi and rema Obs #6 re strap bag blad posi to pl Obs #7, (not s strap reverse belo	lem of an indwe to minimize risk ventions include secure tubing to a secure the coaled the urinary withe bladder.	an update of 1/27/16 for a selling catheter, with the states of complications. The ed observe for symptoms of oresident's thigh to prevent e daily, encourage fluiding for kinks or twists in tubing, ery month. 1/02/2016 at 8:23 AM in main ed Resident #64 was sitting in rinary drainage bag attached be geri-chair. The urinary bove the bladder and was not hat yellow urine was observed and up to drainage bag. 1/02/2016 at 9:26 AM revealed emoved from the dining room of the geri-chair. 1/02/2016 at 9:47 AM with NA and #64 did not have a securing or leg and the urinary drainage had below the level of the sained the drainage bag was morest due to not being able and the drainage bag was morest due to not being able and the drainage bag was eatheter. Further interview drainage bag was positioned NA #7 explained there was place the drainage bag. If				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION		(X3) DATE COMF	SURVEY
		345410	B. WING _			03/	/03/2016
	ROVIDER OR SUPPLIER CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRI DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 282	Interview with the nu 03/02/2016 at 10:05 drainage bag should side of the geri-chair Nurse #2, she went to Inspection of the urine #2, NA # 6 and #7 re bag could be position bladder for proper draining the footrest. Interview securing strap was to resident's leg. Nurse on the leg. Interview with the DO AM revealed she was a securing strap on the lag. Interview with the DO AM revealed she was a securing strap on the lag. Resident #2 was rown a securing strap on the lag. Review of the Minimal form the management with the management with the lower in the lo	rse #2 on 100 hall on AM revealed the urinary not be positioned on the arm . After the interview with o Resident #64's room. hary drainage bag by nurse vealed the urinary drainage hed below the level of the ainage of urine. Nurse #2 ary drainage bag underneath with Nurse #2 revealed a be in place on the e #2 was not aware it was not ON on 03/02/2016 at 10:25 build expect the aides to have the resident and the drainage bladder for proper drainage. e-admitted to the facility on es including dementia and um Data Set (MDS), a 0/15 indicated the resident erm memory problems and with decision making abilities. ally dependent on one staff ily living. Resident #2 had r extremity due to history of	F2	82			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SUI COMPLET		
		345410	B. WING		03/03/	2016	
	ROVIDER OR SUPPLIER CONTINUING CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE C	(X5) COMPLETION DATE	
F 282	diabetes and left ab The interventions in to the right heel at a Observations on 2/2 Resident #2 was se right foot without a h Observations on 3/2 Resident #2 did not the right heel. Interview with Nurse 6:55 AM revealed th have a padded soft right foot. The aide have a boot on her h duty. The aide look did not find a boot to Interview with the D at 9:47 AM revealed to apply the heel pro plan. 4. Resident #2 was 7/12/14 with diagnor contracture. Review of the Minim quarterly, dated 12/1 had long and short to severe impairment of Resident #2 was tot Resident #2 was tot	ove the knee amputation. cluded use of a heel protector	F 28	32			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345410	B. WING		03/03/2016
	ROVIDER OR SUPPLIER CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 282	Continued From page	ge 17	F 282	2	
	12/16/15 included a breakdown. The inf	ot spacer in the left hand to			
	revealed documenta 2/8/16 and 2/19/16 was in place. Revie	splinting flowsheet sheet ation for the dates 2/1 to indicating the carrot spacer ew of the March splinting no documentation for 3/1 to e carrot spacer.			
		1/16 at 3:47 PM revealed the ot in Resident #2's hand.			
		2/16 at 8:30 AM revealed the ot in Resident#2's hand.			
	AM revealed there	sident #2 on 3/3/16 at 9:15 was no device in her left hand. nd closed in a tight fist.			
	(NA) #5 revealed th	16 at 6:55 AM with Nurse Aide e resident did not have b be kept in her hand.			
	03/03/16 at 9:36 AM management of left according to the car revealed she would to apply the carrot in	irector of Nursing (DON) on A revealed contracture hand would be done re plan. Further interview expect the aides on the floor in the resident's hand daily. Cument the device was used storative flowsheet."			
	10:48 AM revealed	Nurse #1 on 03/03/16 at the carrot was to be used to ractures in the left hand.			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030		
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 282		ealed the hand contracture	F 2	82		
F 315 SS=D	had not become wor 483.25(d) NO CATH RESTORE BLADDE	ETER, PREVENT UTI,	F3	15	3/31/16	
	resident who enters indwelling catheter is resident's clinical concatheterization was rewho is incontinent of treatment and service	the facility without an solution and the facility without an solution and the indition demonstrates that necessary; and a resident bladder receives appropriate es to prevent urinary tract tore as much normal bladder				
	by: Based on observation interviews the facility indwelling urinary can the urinary drainage proper drainage for condwelling urinary can the findings included. The findings included Resident #64 admitted with diagnosis included and dysfunction of the Minimum Data Squarterly, indicated Findwelling urinary can the finding urinary can be facility.	theter tubing and maintain bag below the bladder for one of three residents with an theter. (Resident #64) d: ed to the facility on 3/19/15 ling hypertension, dementiane bladder. Set (MDS) dated 1/15/2016, a		1) On 3/21/16, the Director of Nand the Staff Development Coord scheduled mandatory meetings for nursing department staff on 3/22/3/23/16, and 3/24/16 to discuss the implementation of Daily Care Guiserve as an effective reference to staff providing daily care to reside meeting agenda addressed sever including privacy bags for urinary bags, leg straps to secure catheter placement of urinary drainage bathe bladder to prevent infection, to classification and use of restraints proper use of all equipment relates splinting, contracture management devices used for other purposes prevention of skin breakdown and pressure relief. In addition, visual	dinator or all /16, he ides to ool for ents. The ral issues r drainage er tubing, gs below he s, the ed to nt, and like d	

STATEMENT OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345410	B. WING			3/03/2016	
NAME OF PR	OVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	0/00/2010	
				1287 NEWSOME STREET			
CENTRAL (CONTINUING CARE			MOUNT AIRY, NC 27030			
(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 SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	Continued From page	e 19	F 31	5			
	The care plan with an problem of an indwell goal to minimize risk interventions included UTI, secure tubing to pulling, catheter care intake, monitor tubing change catheter ever. The monthly February catheter was to be change catheter was to be changed daily and the 16 French with 5cc (ostraight drainage. Record review reveal infections, with no curbladder. The nurse notes for the indicated the urine was observations on 03/0 dining room, revealed a geri-chair with a uring to the arm rest on the drainage bag was abordaining. Cloudy light in the drainage tubing. Observations on 03/0 Resident #64 was remand taken to her room remained on the arm. Observations on 03/0 Resident #64 Resident #64 revealed Resident #64 revealed Resident #65 revealed Resident #65 revealed Resident #65 revealed Resident #65 revealed Resident	ing catheter, with the states of complications. The dobserve for symptoms of resident's thigh to prevent daily, encourage fluid for kinks or twists in tubing, y month. y 2016 orders indicated the anged monthly, care to be experisize of catheter was subic centimeter) balloon to ded a history of urinary trent infections of the distribution as straw colored. 2/2016 at 8:23 AM in main and Resident #64 was sitting in hary drainage bag attached geri-chair. The urinary dove the bladder and was not at yellow urine was observed grup to drainage bag. 2/2016 at 9:26 AM revealed moved from the dining room in. The urinary drainage bag	F 31	education was provided by using geri-chair and a wheelchair to she options for urinary drainage bag placement. 2) The facility urinary drainage policy was updated on 3/21/16 to the mandatory use of leg straps to tubing and privacy bags or flaps findwelling catheters as well as ur drainage bag placement to be low the bladder to prevent infection. 3) The Director of Nursing and management team met on 3/21/1 discuss necessary changes to en privacy bags and leg straps were mandatory. The decision was manadd these items to the Treatment Administration Record (TAR). This procedure change will prevent the absence of these necessities from occurring again. Signing off on the items by the treatment staff will be performed daily. 4) Procedures will be assessed reviewed at the upcoming quarter meeting. Chart reviews will continued weekly basis. Noted issues will continued to be remedied immediately by the nurse and ADON. Areas of conceaddressed in quarterly committee meetings. All changes to procedure meetings. All changes to procedure compliance.	catheter include of secure for all inary wer than the nurse of to sture de to see e and rly QAA nue on a continue see QA ern will be edires or		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY LETED
		345410	B. WING			03/	03/2016
	ROVIDER OR SUPPLIER CONTINUING CARE		•	12	REET ADDRESS, CITY, STATE, ZIP CODE 287 NEWSOME STREET OUNT AIRY, NC 27030	•	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315	bladder. NA#6 explain positioned on the arm to place it anywhere explains to place it anywhere explains to place it anywhere expressed to reside the urinary of below the bladder. Nowhere different to placed on the foot residence on the chair was proposition for meals. Interview with the nurrous form the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair. Nurse #2, she went to the side of the geri-chair.	ned the drainage bag was rest due to not being able else on the geri chair. //2016 at 9:50 AM with NA lent #64) revealed she was at was supposed to have a attheter. Further interview drainage bag was positioned A #7 explained there was blace the drainage bag. If at frame, it would be caught ositioned in an upright	F	315			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345410	B. WING		03/03/2016	
	ROVIDER OR SUPPLIER CONTINUING CARE	,	1	STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030	,	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 318 F 318 SS=D	483.25(e)(2) INCREA IN RANGE OF MOTI	ASE/PREVENT DECREASE	F 318 F 318		3/31/16	
	resident, the facility n with a limited range of	nust ensure that a resident of motion receives t and services to increase or to prevent further				
	by: Based on observation interview and staff i	re. This was for two of three ative nursing. I: admitted to facility on ed on 9/27/15. The most luded chronic pain, muscle ed lack of coordination and		1) On 3/3/16, it was identified that Resident #92 had restorative needs the were not conveyed from the therapy department to the nursing department Once revealed, the Restorative Nurse wrote the recommendations up on the restorative flowsheet, educated the has staff about the current restorative need and provided education about the type exercises. The Restorative plan was the implemented per therapy serecommendations. 2) On 3/9/16, the Occupational There evaluated Resident #2 based on a nur staff report of mixed use with the left hand. OT determined that it was not necessary to continue the use of the carrot orthotic because the resident displayed abnormal reflex activity with	II ds, es of nen apist sing	
	#92 had a Brief Inter (BIMS) of 13 which ir memory was intact. #92 required extensiv all activities of daily li	view for Mental Status ndicated long and short term This MDS indicated Resident ve assistance of one staff for ving (ADLs). Review of the ent #92 did not ambulate.		minimal contracture. A physician order was obtained to discontinue the carrot 3/9/16. 3) The Director of Nursing conducted pre-scheduled, monthly nursing department meetings which were held	on d	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345410	B. WING _		03	/03/2016	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD	•		
				1287 NEWSOME STREET			
CENTRAL	CONTINUING CARE			MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 318	Continued From pag	e 22	F 3	18			
	had limited functiona her upper body and p transfer.	I movement on one side of coor balance for sitting and ed occupational therapy (OT)		3/8/16 and 3/14/16. The topic care related to the restorative was discussed. The Director of and the Staff Development Coscheduled mandatory meeting	program of Nursing pordinator		
	from 9/28/15 to 11/4/ discharge summary	15. Review of the OT dated 11/4/15 indicated seen for active range of		nursing department staff on 3 3/23/16, and 3/24/16 to discussimplementation of Daily Care	/22/16, ss the		
	management, transfe discharge the reside	e right upper extremity, pain er, and self- feeding. Upon nt was able to self-feed, and assist of 2 staff. Staff		serve as an effective reference staff providing daily care to re meeting agenda addressed so including privacy bags for uring	sidents. The everal issues		
	upper extremity to m	educated in AROM of right anage pain levels and otion for functional use.		bags, leg straps to secure cat placement of urinary drainage the bladder to prevent infection classification and use of restra	heter tubing, e bags below on, the		
	therapist on 11/3/15 would begin on 11/9/	eferral "signed by the indicated Restorative care 15. This form was the tation between therapy and		proper use of all equipment re splinting, contracture manage devices used for other purpos prevention of skin breakdown	elated to ement, and ses like		
	restorative nursing. will perform towel glid and back, also, side	The goals included "Patient des on table surface forward to side. 20 reps (repetitions) t Shoulder." The program		pressure relief. The important identifying and reporting chan resident status was also discu order to maintain function and	ce of ges in ussed in		
	included bilateral upp to be provided 5 tim	per extremity range of motion less a week.		worsening conditions. Proper program functions were also cannot be a supported by the support of	restorative discussed. rill be listed		
	11/18/15 to 12/1/15. for standing balance			on the daily care guide. Clarif offered as to the types of exer were currently recommended and what ADL functions were to those types of movement. I specifically addressed that CN	rcises that for residents equivalent It was NAs		
	12/8/15. The goals i (patient) current fund AROM on BLE (bilate	rative care would begin on ncluded " Maintain pt tional status. Maintain eral lower extremities) " The tient will perform BLE AROM		assigned to each hall were re performing the restorative fun ordered. Proper documentation restorative flowsheet will service compliance. Frequent monitor Restorative Nurse will take plant and the plant is a service will be plant in the plant in the plant in the plant is a service will be plant in the plant is a service will be plant in the	ctions as on on the e a proof of ring by the		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345410	B. WING		03/03/2016
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2010
				1287 NEWSOME STREET	
CENTRAL	CONTINUING CARE			MOUNT AIRY, NC 27030	
(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 COMPLETION
F 318	Continued From page	e 23	F 31	8	
	Patient will perform tr wheelchair with a roll guard assist. Review of the care pl included a problem o	s 2 times for 20 repetitions. ansfers to and from the ing walker with contact an updated on 1/13/16 f impaired mobility related to		4) As of 3/23/16 the Restorative Program will be conducted as such a restorative need has been identificated determined by the therapy department the recommendation(s) will be communicated on a Restorative Reform and the staff will be educated particular type of exercises to be	ed or ent, ferral
	nursing once she has for a maintenance pro	efer resident to restorative reached her max potential ogram. The therapy and 12/1/15 were not		particular type of exercises to be performed. Copies of the referral fo be given to the MDS/Care Plan nur and to the Restorative Nurse. The oplan will be updated. The referral w written up on a restorative flowshed the Assistant Director of Nursing	ses care ill be
	revealed the plan inclower extremities and was discharged from little effort to feed self	tive nursing plan of care uded range of motion to the transfers. Resident #92 restorative dining due to "f." The restorative plan for extremity was not in the re.		(functioning as the Restorative Numplaced in the appropriate Restorative book designated by each resident have additions or changes to daily complete be added to the resident sindividuate care guide. The hall staff will have a to the restorative recommendations each book will be kept on its designation.	ve nall. are will ual daily access s as
	aides revealed the ex extremities were bein five days a week in F	entation by the restorative sercises to the bilateral lower g done for 15 minutes for ebruary 2016. There were ed restorative care provided es.		hall. 5) Once the Restorative plan has written up by the Restorative Nurse referral form is placed in the reside medical chart behind the Restorative (6) The therapy department will fo and ensure compliance by keeping	been e, the nt⊡s ve tab. Ilow up
	#92 revealed staff did exercises to her arms indicated it had been had any exercises. An interview with Nur	s or legs. Resident #92 a " long while " since she se Aide (NA) #5 who had		to date, running list of residents in r a restorative plan. This list will be categorized by resident name, start restorative recommendations and frequency of exercises. A reassess date will also be scheduled for each resident to evaluate appropriateness	meed of t date, ment n ss and
	February 2016 was c	cises were provided in onducted on 3/3/16 at 8:30 d the NA 's on the halls		possible continuation of the program 7) Procedures will be assessed a reviewed at the upcoming quarterly	nd

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345410	B. WING _			03/	03/2016
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE			12	TREET ADDRESS, CITY, STATE, ZIP CODE 287 NEWSOME STREET IOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 318	interview revealed ex getting her up and ou showers. When NA# activities were the said 20 repetitions she state explained she had be restorative program won the floor were to dasked if she had provaccording to the restoreplied not always. Interview with the The 8:58 AM revealed Refrom therapy (PT) on Referrals had been on that would include traback with rolling walk extremities. He further would be lateral leg liknee flexions. When same as the movement stated "no." The Trexplained Resident freexercises by herself. provided the referral for towel glides on table also side to side 20 referring the towel glides on table also side to side 20 referring the towel glides on table also side to side 20 referring the towel glides on table also side to side 20 referring the recommendations. Interview with the Direction of the restorative per the recommendations. That nurse would write the said of the said of the restorative per the recommendations. That nurse would write the said of the said of the restorative per the recommendations.	e care for residents. Further ercises were counted as t of bed, dressing, and 5 was asked if those me as providing AAROM for sted "no." She further een a restorative aide. The was changed and the NA's of the exercises. When rided the exercises when rided the exercises orative plan of care she erapy Director on 03/03/16 at sident #92 was discharged 12/7/15 and OT on 11/4/15. Communicated to restorative ensfers from wheelchair and er, AROM of lower er explained "all planes" fit away from the body and asked if these would be the ents during daily care he herapy Director further	F	318	meeting. Chart reviews will continue or weekly basis. Noted issues will continue to be remedied immediately by the QA nurse and ADON. Areas of concern wil addressed in quarterly committee meetings. All changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	e I be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345410	B. WING			03/	/03/2016
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE		•	STREET ADDRE 1287 NEWSON MOUNT AIRY				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL DSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 318	usually be a daily tre 7-3, then 3-11 would received communica nurse regarding any would inform the hall changes or additions Interview on 03/03/1 revealed she would of restorative as indicat further explained with aides it was difficult to During the interview made an attempt to of like for it to be done Further interviews re provided to the nursi it was more on them Interview with the res 10:15 AM revealed to provided the restorat flowsheets. For Res provide transfers to/f rolling walker and AF Further interview rev NA's to do the 20 re restorative nurse wa restorative care was their documentation. she had not observe care and was not aw provided. During the nurse explained she communication form	's. Restorative care would atment. If it was not done on pick it up. The hall nurses tion from the restorative changes. The hall nurse NA's of any treatment, is. 6 at 9:49 AM with the DON expect the aides to do the program. She nout designated restorative to carry out the program. The DON explained the aides do the program, we would like it was on the flowsheet. It was on the flowsheet wealed education was not staff and they understood to do. Storative nurse on 03/03/16 at the NA's on the floor live care according to the ident #92 the NA's would rom wheelchair with the ROM of the lower extremities. The saked how she ensured the provided, she replied by "Further interview revealed the NA's providing the lare it was not being a interview the restorative had not received the	F	318			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345410	B. WING		03/03/2016		
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE SUMMARY STATEMENT OF DESIGNATIONS				STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030	, 00,00,20.0		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION		
F 318	2. Resident #2 was 7/12/14 with diagnos contracture. Review of the Minim quarterly, dated 12/1 had long and short to severe impairment of Resident #2 was tot for all activities of dalimitation of the lower an amputation of on Review of the care proceed to the severe impairment of the lower an amputation of on Review of the care proceed to the severe impairment of the lower an amputation of a carromaintain left hand proceed to the severe impairment of the lower and the seview of the care proceed to the seview of the seview of February revealed documents 2/8/16 and 2/19/16 in was in place. Review flowsheet revealed the seview of the carrot spacer was not consider the seview of the	re-admitted to the facility on sees including dementia and um Data Set (MDS), a 10/15 indicated the resident erm memory problems and with decision making abilities. ally dependent on one staff ally living. Resident #2 had er extremity due to history of e leg. In olan with an update of em of potential for skin erventions included but spacer in the left hand to obsitioning daily. In old the spacer wo fit the dates 2/1 to indicating the carrot spacer wo fit the March splinting no documentation for 3/1 to	F 31	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345410	B. WING _		03/	03/2016
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318	03/03/16 at 9:36 AM management of left haccording to the care revealed she would et to apply the carrot in The aides would docuon the "splinting resillatories with the resilication on the "splinting resillatories with the resilication on the "splinting resillatories with the resilication of the provided the restoration of the provided, she replied interview with the resillatories with the resilication of the provided of the provided, she replied interview with the resillatories	ector of Nursing (DON) on revealed contracture and would be done plan. Further interview expect the aides on the floor the resident 's hand daily. Imment the device was used to rative flowsheet." It to rative nurse on 03/03/16 at e NA's on the floor ve care according to the prative nurse was asked restorative care was "by their documentation." It to rative nurse on 03/03/16 at esident #2 was to have a fit hand for at least 4 all day. Observation with the	F3	318		
F 356 SS=D	10:48 AM revealed the prevent further contral Further interview revealed not become worst 483.30(e) POSTED NINFORMATION The facility must post a daily basis: o Facility name. o The current date.		F3	956		3/31/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345410	B. WING	 -	03/03/2016		
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030	·		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 356	Continued From pag	je 28	F 3	56			
	unlicensed nursing sesident care per shine - Registered nurse - Licensed practivocational nurses (and - Certified nurses on Resident census. The facility must possipecified above on a conference of each shift. Datain on Clear and readable of In a prominent plantesidents and visitor. The facility must, up make nurse staffing for review at a cost in standard. The facility must mastaffing data for a mine staffing data for a mine resident care per standard.	ses. cal nurses or licensed s defined under State law). aides. st the nurse staffing data a daily basis at the beginning must be posted as follows: e format. ce readily accessible to					
	by: Based on observation facility failed to post data for 4 of 4 days of survey conducted 2/2. The findings include During the initial tour 7:30 AM the nurse subserved to be posterinclude the facility namber of licensed as			1) On 3/3/16, the staffing coord the Director of Nursing, and the Administrator discussed the requirelated to Posted Nurse Staffing Information. While the facility nancensus, current date, actual hours for RNs, LPNs, and CNAs, and to number of staff in each category listed for all 3 shifts, the total numbours worked was missing. The tonumber of hours worked was add	irement ne, s worked otal was nber of		

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3	B) DATE SURVEY COMPLETED
		345410	B. WING _			03/03/2016
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE CUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 356	information form did rand it was posted for An observation for 4 of 3/1/16, 3/2/16 and 3/3 nurse staffing form we include the census, to for all 3 shifts and did worked for licensed a During an interview woon 3/3/16 at 8:50 AM posting the nurse staffing coordinator p number of licensed and provided the data indicated that she waneeded to include the worked. An interview with the 9:00 AM confirmed the posted each morning aware that the nurse the total number of hounlicensed nursing staffing the form will be correctly interested the correctly interested that she waneeded to include the worked.	not include the actual hours all 3 shifts. consecutive days 2/29/16, 8/16 at 10:00AM revealed a as posted each morning to otal number of nursing staff not include the actual hours and unlicensed nursing staff. With the staffing coordinator who is responsible for fing form indicated that she affing form the day prior and changes each shift. The rovided the date, census, and unlicensed nursing staff a for all 3 shifts. She further is not aware that the data at the nurse staffing data is for all 3 shifts, he was not staffing form did not include ours worked for licensed and aff. He further indicated that cited today to indicate the	F3	current day s posted informatic 2) On 3/3/16, nursing supervieducated by the Director of Nursing this form daily and as staff hours change. 3) On 3/21/16, the staffing count and the Director of Nursing reviewed Nurse Staffing Informatic document to include a section for the total number of worked. 4) The Director of Nursing and management team met on 3/2 discuss the Posted Staff Nurse Information requirement. All management stated understanding. Changes to this procedure were the upcoming monthly nursing staff meeting agenda. 5) On 3/21/16, the policy on Information was include all the required information. Procedures will be assess reviewed at the upcoming quar meeting. Changes to procedure processes will be implemented immediately if necessary. The Administrator is responsible for compliance.	isors were rsing on updating it pordinator ised the ion specifically hours. In the end of the end o	t t
F 520 SS=D	COMMITTEE-MEMB QUARTERLY/PLANS		F 5	20		3/31/16
	assurance committee nursing services; a ph	in a quality assessment and consisting of the director of hysician designated by the other members of the				

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED		
		345410	B. WING		03/03/2016		
	(***)				1 33/03/2313		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION		
F 520	Continued From pag	ge 30	F 52	20			
	issues with respect to and assurance active develops and impler action to correct identification and implementation of the recurrence of such requirements of this Good faith attempts	least quarterly to identify to which quality assessment ities are necessary; and ments appropriate plans of ntified quality deficiencies. Letary may not require ords of such committee ch disclosure is related to the committee with the section. by the committee to identify eficiencies will not be used as					
	by: Based on observation and staff interviews, Assessment and Assimplement, monitor action plan developed identified during the 4/23/2015 in order to compliance. The fact deficiency at F 241. facility during two feshowed a pattern of sustain an effective. The findings include This tag is cross-refeef 241 Based on obsinterviews the facility residents' privacy by	surance committee failed to and revise, as needed, the ed for the deficiencies recertification survey dated a achieve and sustain cility had a repeated. The continued failure of the deral surveys of record the facility's inability to Quality Assurance Program. d:		1) On 3/21/16, a Department Head/Management team meeting way held to discuss Quality Assessment Assurance (QAA) committee requirements. 2) The facility (QAA) committee with quarterly. 3) The QAA committee meeting again will include current and past survey deficiencies. 4) An action plan will be developed concerns and deficiencies identified during the survey process. Efforts to prevent repeated deficiencies will be evaluated by the QAA committee bas on the action plan interventions such staff education and policy changes of updates that will prevent further.	and Il meet Jenda If for all seed ass		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED			
		345410	B. WING		03	3/03/2016		
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE			•	STREET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 520	and Resident #98). It survey of 4/23/2015 to for failing to provide a during a meal, resulting experience for a resident the Administrator was 11:30 am. He explair meets quarterly to adhave not identified issembled indicated that they have of indwelling cath	During the recertification he facility was cited at F 241 assistance with toileting ng in an undignified dining dent. s interviewed on 3/3/2016 at ned that the committee dress concerns, but they	F 52	deficiencies in the same areas. 5) The updated QAA committ procedures will be assessed ar at each quarterly QAA meeting changes will be made immedia necessary. The Administrator is responsible for overall compliant.	tee nd reviewed and tely if s			