MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	345420	B. WING		C 08/11/2016
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CE HEALTH CARE CENT	FR		1987 HILTON STREET	
			BURLINGTON, NC 27217	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
		F 27	78	9/3/16
The assessment mus resident's status.	t accurately reflect the			
each assessment wit	h the appropriate			
assessment must sig	n and certify the accuracy of			
willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a resident assessment	y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money			
-				
by: Based on record rev facility failed to accur Data Set (MDS) asse psychotropic medicat residents (Resident # unnecessary medicat	iew and staff interviews, the ately code the Minimum ssment to reflect the ions received for 1 of 5 228) reviewed for tions.		herein. The plan of correction is completed in the compliance of state a	and
	RS FOR MEDICARE & OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER CE HEALTH CARE CENT SUMMARY ST. (EACH DEFICIENC REGULATORY OR I 483.20(g) - (j) ASSES ACCURACY/COORE The assessment must resident's status. A registered nurse mile aach assessment wit participation of health A registered nurse mile assessment is compliant Each individual who context assessment must sig that portion of the asses Under Medicare and willfully and knowinglight false statement in a mile subject to a civil moni \$1,000 for each asses Willfully and knowinglight to certify a material and resident assessment penalty of not more that assessment. Clinical disagreement material and false state This REQUIREMENT by: Based on record reverting facility failed to accurred pasychotropic medicated residents (Resident # unnecessary medicated	F CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 4483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED 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. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment to reflect the psychotropic medications received for 1 of 5 residents (Resident #228) reviewed for unnecessary medications.	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING GROVIDER OR SUPPLIER 345420 B. WING	SS FOR MEDICARE & MEDICAID SERVICES or DEFICIENCIES (x1) PROVIDERINGUPULERCLIA DESTRICTATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 346420 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 1987 HILTON STREET BUILDING CE HEALTH CARE CENTER ID SUMMARY STATEMENT OF DEFICIENCES (BACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDEMITIVES INFORMATION) PROVIDERS PLAN OF CORRECTION (BACH DEPICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDEMITIVES INFORMATION) 483.20(0) - (i) ASSESSMENT ACCURACY/CORDINATION/CERTIFIED F 278 The assessment must accurately reflect the resident's status. F 278 A registered nurse must conduct or coordinate each assessment is completed. F 278 Each individual who completes a portion of the assessment is completed. F 278 Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment is origen to a servidenced by: The statements included are not an admission and do not constitute a material and false statement in resident \$28,000 servisement to reflect the resident \$28,000 systems must to reflect the penalty of not more than \$5,000 for each assessment. The statements included are not an admission and do not constitute a material and false statement to reflect the penalty of not more than \$5,000 for each assessment.

Electronically Signed

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.

09/02/2016

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/201 M APPROVEI D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>		CONSTRUCTION	COM	E SURVEY PLETED
		345420	B. WING				C / 11/2016
NAME OF P	ROVIDER OR SUPPLIER	·		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANC	E HEALTH CARE CENT	ER			87 HILTON STREET JRLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From page	e 1	F 2	78			
	The findings included				in compliance with all federal and stat regulations the center has taken or wi take the actions set forth in the followi	ll ng	
	12/18/15 from a hosp diagnoses included a	dmitted to the facility on bital. His cumulative Inxiety, depression, and			plan of correction. The following plan correction constitutes the center⊡s allegation of compliance. All alleged		
	psychotic disorder.				deficiencies cited have been or will be completed by the dates indicated.		
		#228 's medical record					
		5 admission medication art: 100 milligrams (mg)			How corrective action will be accomplished for each resident found	to	
	quetiapine (an antips	ychotic medication) to be			have been affected by the deficient	10	
	given as one tablet by of Resident #228 ' s (y mouth once daily. A review Order Summary for			practice On August 30, 2016, the MDSC modif	ïed	
	December 2015 reve received for an antiar				residents		
		#228 's admission Minimum essment dated 12/24/15 was			this medication class.		
		N of the MDS assessment			How corrective action will be		
		antianxiety medication on 7			accomplished for those residents havi the potential to be affected by the sam		
	out of 7 days during t				deficient practice: All medical records for current resider		
	record revealed a Ca	sident #228 ' s medical re Area Assessment (CAA) otropic Drug Use was			receiving an anti-psychotropic medica will be audited by September 3, 2016 ensure that their anti-psychotropic		
	completed on 12/28/2	15. The CAA indicated aking both an antipsychotic			medication was coded correctly on the most recent MDS. The MDSs were	eir	
	and antianxiety media				modified by the MDSC for any coding errors identified in the audit, and		
	on 8/11/16 at 2:50 PM	ducted with MDS Nurse #1 /. During the interview, the			completed by September 3, 2016.		
		S assessment (Section N)			Measures to be put in place or system changes made to ensure practice will		
	discussed. Upon rev	he CAA Worksheet was iew of Resident #228 ' s			re-occur: On 8/29/16, the MDSC Consultant		
		rse reported she was unable indicate the resident actually			provided education to the MDSC that anti-psychotropic medication that a	any	

Facility ID: 932930

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	co	MPLETED
		345420	B. WING			C 8/11/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/11/2010
ALAMANO	CE HEALTH CARE CENT	ER		1987 HILTON STREET BURLINGTON, NC 27217		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 278	received an antianxie MDS 7-day look back An interview was con Director of Nursing (E During the interview, antianxiety medicatio #228 ' s MDS assess inquiry, the DON state	ty medication during the c period. ducted with the facility ' s DON) on 8/11/16 at 3:58 PM.	F 27	 8 resident receives during the 7 d back period of the ARD of the M be accurately coded in section MDS. How facility will monitor correcting action(s) to ensure deficient pranot re-occur: The MDS Consultant will audit & residents MDS who are received anti-psychotropic medication to the medication was correctly contheir MDS for the schedule listed This will be done 1 week for 4 w twice a month for 1 month, and for 4 month. Any coding issue is on the audits will be immediated 	IDS must N of the ve ctice will 5 current ving ensure ded on d below. veeks, monthly dentified	
F 279 SS=D	to develop, review an comprehensive plan o The facility must deve	CARE PLANS e results of the assessment d revise the resident's	F 27	corrected with coaching/discipli needed to the MDS. The issue presented to completion or revis needed within the QA program. 9	will be	9/3/16
	medical, nursing, and needs that are identif assessment. The care plan must d	bles to meet a resident's I mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's nysical, mental, and				

If continuation sheet Page 3 of 9

-					M APPROVE D. 0938-039
DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
	345420	B. WING		08	C / 11/2016
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HEALTH CARE CENT	ER		1987 HILTON STREET BURLINGTON, NC 27217		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE
asychosocial well-bein (483.25; and any ser- pe required under §48 lue to the resident's of (483.10, including the inder §483.10(b)(4). This REQUIREMENT by: Based on record revin acility failed to develop the use of psychotrop esidents (Resident # innecessary medicat The findings included Resident #228 was and 2/18/15 from a hosp liagnoses included and bychotic disorder. A review of Resident f evealed his 12/18/15 orders included, in pa juetiapine (an antipsy jiven as one tablet by A review of Resident f Data Set (MDS) asse- evealed the resident everely impaired cog lecision making. He assistance for his Acti Section N of the MDS part, that the resident	ng as required under vices that would otherwise 33.25 but are not provided exercise of rights under e right to refuse treatment ' is not met as evidenced ew and staff interviews, the op a care plan to address bic medications for 1 of 5 228) reviewed for ions. : dmitted to the facility on ital. His cumulative nxiety, depression, and #228 ' s medical record i admission medication int: 100 milligrams (mg) ychotic medication) to be y mouth once daily. #228 ' s admission Minimum ssment dated 12/24/15 was assessed to have gnitive skills for daily required extensive ivities of Daily Living (ADLs). assessment indicated, in received an antipsychotic	F 27	 How corrective action will be accomplished for each resident have been affected by the defice practice On August 10, 2016, the MDSC residents□ #228 care plan for t antipsychotic medication. How corrective action will be accomplished for those resider the potential to be affected by the deficient practice: All medical records for current receiving an anti-psychotropic medication will be audited September 3, 20 ensure that their anti-psychotropic most recent comprehensive MI care planned as indicated in the The MDSs were modified by the for any coding errors identified audit, and completed by Septer 2016. Measures to be put in place or changes made to ensure practire-occur: 	cient C updated the use of hts having the same residents medication 016 to opic y on their DS and e CAA. e MDSC in the mber 3, systemic ice will not	
	FOR MEDICARE & DEFICIENCIES ORRECTION VIDER OR SUPPLIER HEALTH CARE CENT SUMMARY ST, (EACH DEFICIENC REGULATORY OR I Continued From page by chosocial well-bei (483.25; and any ser pe required under §44 lue to the resident's of (483.10, including the inder §483.10(b)(4). This REQUIREMENT by: Based on record revia acility failed to develo he use of psychotrop esidents (Resident # unnecessary medicat The findings included Resident #228 was an (2/18/15 from a hosp liagnoses included a vsychotic disorder. A review of Resident evealed his 12/18/15 orders included, in pa juetiapine (an antipsy jiven as one tablet by A review of Resident Data Set (MDS) asse evealed the resident severely impaired cog lecision making. He issistance for his Act Section N of the MDS part, that the resident	ORRECTION IDENTIFICATION NUMBER: 345420 VIDER OR SUPPLIER HEALTH CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 syschosocial well-being as required under (483.25; and any services that would otherwise be required under §483.25 but are not provided lue to the resident's exercise of rights under (483.10, including the right to refuse treatment ander §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the acility failed to develop a care plan to address he use of psychotropic medications for 1 of 5 esidents (Resident #228) reviewed for innecessary medications. The findings included: Resident #228 was admitted to the facility on 2/18/15 from a hospital. His cumulative liagnoses included anxiety, depression, and sychotic disorder. A review of Resident #228 's medical record evealed his 12/18/15 admission medication riders included, in part: 100 milligrams (mg) yuetiapine (an antipsychotic medication) to be jiven as one tablet by mouth once daily. A review of Resident #228 's admission Minimum Data Set (MDS) assessment dated 12/24/15 evealed the resident was assessed to have ieverely impaired cognitive skills for daily lecision making. He required extensive ussistance for his Activities of Daily Living (ADLs). Section N of the MDS assessment indicated, in part, that the resident received an antipsychotic medication on 7 out of 7 days during the look	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES ORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIF A. BUILDING 345420 B. WING	FOR MEDICARE & MEDICAID SERVICES DEFIGIENCIES (x1) PROVIDERSUPPLIERCLIA DERECTION (x2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, 2P CODE UNING TO LSC IDENTFYING INFORMATION) ID REGULATORY OR LSC IDENTFYING INFORMATION) ID REGULATORY OR LSC IDENTFYING INFORMATION) ID PREPX CRONTRECTWE ADTORY OR LSC IDENTFYING INFORMATION) Continued From page 3 F 279 Continuer S483.25 Ut are not provided lue to the resident secrets or titks How corrective action will be accomplished for each resident have been affected by the define practice Continuer S483.25 Unternot provided lue to the resident secrets and balage How corrective action will be accomplished for those residen practice The findings included: How corrective action will be accompl	FOR MEDICARE & MEDICAID SERVICES OND IN DEFICIENCIES (x1) PROVIDERSUPPLIFICATION (x2) MULTIFLE CONSTRUCTION (x0) DUIT DEFICIENCIES (x2) MULTIFLE CONSTRUCTION (x0) DUIT NUMB 345420 IN WIG (x0) DUIT WIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURNOW STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET UPUEX PROVIDERS FLAW (C) ORDERCTON FROM REPORTING AT ON HOULD BE (READ ORDERCTON WIDT HERE) AND ROMANTON) PROVIDERS FLAW (C) ORDERCTON FLAW (C) ORDERS FLAW (C) ORDERCTON FLAW (C) ORDERS FLAW (C) ORDERS FLAW (C) ORDERTON FLAW (C) ORDERS FLAW (C) ORDERS FLAW (C) ORDERS FLAW (C) ORDERTON FLAW (C) ORDERS FLAW (C) ORDERS FL

Facility ID: 932930

STATEMENT (F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SU	<u>938-039</u> RVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:		i	COMPLE	ΓED
			5.4/040		С	
		345420	B. WING		08/11/	2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
ALAMANO	E HEALTH CARE CENT	ER		1987 HILTON STREET BURLINGTON, NC 27217		
(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 ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From page	2 4	F 27	9		
	A review of Resident revealed a Care Area Worksheet for Psycho completed on 12/28/1 included in the CAA W nature of the problem "Resident has a Dx (o Depressive Psychosis antipsychotics meds CAA Worksheet revea would be addressed in plan. The overall obje problem was noted as A review of Resident 12/21/16) revealed th Use was not address On 1/11/16, a physici change Resident #22 medication from quet (another antipsychotic A review of Resident included the June 20 Record (MAR). Acco the resident received as ordered for psycho A review of Resident quarterly MDS assess completed. Section N resident received an 7 out of 7 days during	 #228 's medical record Assessment (CAA) otropic Drug Use was 15. The analysis of findings Worksheet described the d/condition as follows: diagnosis) of Mood Disorder, sResident is on " Further review of the aled Psychotropic Drug Use in Resident #228 's care ective for care planning this s: " Avoid complications." #228 's care plan (initiated the topic of Psychotropic Drug ed as a focus area. an 's order was received to to the statistic of the aled record as a focus area. an 's order was received to the topic of Psychotropic Drug ed as a focus area. an 's order was received to the topic of the statistic of the antipsychotic is a preceived to the topic of the statistic of the statistic of the transformed to the statistic of the statistic of the statistic of the transformed to the statistic of the statistic of the statistic of the transformed to the statistic of the statistic of the statistic of the transformed to the statistic of the statistic of the statistic of the statistic of the sment dated 6/10/16 was N of the MDS indicated the antipsychotic medication on g the look back period. e plan did not address the 		 Care Area Assessment, inclu Anti-psychotropic medication needing care planning, is to in the resident s care plan. How facility will monitor corre action(s) to ensure deficient not re-occur: The MDS Consultant will aud residents comprehensive M receiving anti-psychotropic m ensure the item was care pla CAA addressed that the item to be care planned, for the s follows: 1 week for 4 weeks twice a month for 1 month, a for 4 months Any coding issue identified c will be immediately corrected coaching/discipline as needed MDS. The issue will be press completion or revision as ne the QA program. 	n, indicated as be addressed ective practice will dit 5 current ADS who are nedication to anned if the n would need chedule as , nd monthly on the audits d with ed to the sented to	
		ducted with MDS Nurse #1				

If continuation sheet Page 5 of 9

	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 09/12/2016 MAPPROVED D. 0938-0391
NCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345420	B. WING				C / 11/2016
R SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
H CARE CENT	ER					
EACH DEFICIENC	Y MUST BE PRECEDED BY FULL					(X5) COMPLETION DATE
(16 at 2:14 PM rted a resident to address the ion if one was view was con- of Nursing (E quiry, the DO e for psychotre chotic medica- ent receiving se ated Resident d and she acl- ion had not b- the DON re- notropic medica- the 228 ' s car w. i) FOOD PRC/ /PREPARE/S lity must - sure food from red satisfacto- ies; and e, prepare, dis- anitary condit	 M. Upon inquiry, MDS Nurse it 's care plan typically e use of an antipsychotic s prescribed for the resident. ducted with the facility 's DON) on 8/10/16 at 2:55 PM. N reported her expectation ropic drugs (including tions) to be care planned for such a medication. The :#228 's care plan was knowledged an antipsychotic een care planned for the eported a focus area related cations was added to e plan on the date of the DCURE, ERVE - SANITARY A sources approved or ry by Federal, State or local stribute and serve food ions is not met as evidenced n, staff interview and record led to keep walk in cooler on the floor, failed to label 			have been affected by the deficient	0	9/3/16
	R SUPPLIER H CARE CENT SUMMARY ST SUMMARY ST EACH DEFICIENC EQULATORY OR I ed From page (16 at 2:14 PM rted a resident to address th ion if one was view was con of Nursing (E quiry, the DO e for psychotr chotic medica: ated Resident d and she acl ion had not b- t. The DON re- hotropic medica ated Resident d and she acl ion had not b- t. The DON re- hotropic medica in #228 ' s car <i>N</i> . i) FOOD PRC /PREPARE/S ility must - sure food from red satisfactories; and e, prepare, dis anitary condit EQUIREMENT on observation the facility failant anding water of and and and water of and and water of and and water of and an	ION IDENTIFICATION NUMBER: 345420 R SUPPLIER H CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) ed From page 5 (16 at 2:14 PM. Upon inquiry, MDS Nurse rted a resident 's care plan typically to address the use of an antipsychotic ion if one was prescribed for the resident. view was conducted with the facility 's of Nursing (DON) on 8/10/16 at 2:55 PM. quiry, the DON reported her expectation e for psychotropic drugs (including chotic medications) to be care planned for ent receiving such a medication. The ated Resident #228 's care plan was d and she acknowledged an antipsychotic ion had not been care planned for the t. The DON reported a focus area related hotropic medications was added to at #228 's care plan on the date of the M. i) FOOD PROCURE, //PREPARE/SERVE - SANITARY lity must - sure food from sources approved or red satisfactory by Federal, State or local	NCIES ION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD IDENTIFICATION NUMBER: (X2) MUL A. BUILD R SUPPLIER IDENTIFICATION NUMBER: (X2) MUL A. BUILD IDENTIFICATION NUMBER: B. WING R SUPPLIER IDENTIFICATION NUMBER: ID PREF H CARE CENTER ID SACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) PREF ed From page 5 F ID ID rife a resident 's care plan typically to address the use of an antipsychotic ion if one was prescribed for the resident. F view was conducted with the facility 's to following (DON) on 8/10/16 at 2:55 PM. quiry, the DON reported her expectation e for psychotropic drugs (including chotic medications) to be care planned for int receiving such a medication. The ated Resident #228 's care plan was d and she acknowledged an antipsychotic ion had not been care planned for the t. The DON reported a focus area related notropic medications was added to nt #228 's care plan on the date of the <i>N</i> . F I) FOOD PROCURE, //REPARE/SERVE - SANITARY F Ility must - tree food from sources approved or red satisfactory by Federal, State or local les; and e, prepare, distribute and serve food anitary conditions F QUIREMENT is not met as evidenced on observation, staff interview and record the facility failed to keep walk in cooler anding water on the floor, failed to label F	NOTES ION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING	NOES (X1) PROVIDERSUPPLETICULA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING R SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE H CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES SCHAMARY STATEMENT OF DEFICIENCIES EQULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIDENCE ACTION SHOLD DE CROSS-REFERENCED TO THE APPROPRIE DEFICIENCY) ed From page 5 F 279 r16 at 2:14 PM. Upon inquiry, MDS Nurse red a resident 's care plan typically to address the use of an antipsychotic ion if one was prescribed for the resident. F 279 view was conducted with the facility 's of Nursing (DON) on 81/07/16 at 2:55 PM. quiry, the DON reported her expectation e for psychotropic drugs (including thotic medications) to be care planned for the reported an antipsychotic ion had not been care planned for the reported and state or local tes; and e., prepare, distribute and serve food anitary conditions F 371 VIEVENENT is not met as evidenced on observation, staff interview and record the facility failed to keep walk in cooler unding water on the floor, failed to label How corrective action will be accomplished for eaction will be accomplished for eaction will be	IEDICARE & MEDICAND SERVICES OMB MC NOTES (X1) PROVIDER/SUPPLER/CLIA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DUTIPLE COM R SUPPLIER 345420 B WING 08 H CARE CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 1987 HILTON STREET SUMMARY STATEMENT OF DEFICIENCIES BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES ID SUMMARY OR LSC IDENTIFYING INFORMATION) ID Tag CROSTRUCTION OR \$10010 AB CONTORING DON ON \$101010 AB CROSTRUCTION OR \$20010 AB Contract of Contract State or Incurrent State AB F 279 View was conducted with the facility 's F 371 Of Nursing (DON) on \$101016 at 2:55 PM. F 371 PRE

Facility ID: 932930

If continuation sheet Page 6 of 9

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		345420	B. WING			C 08/11/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (00/11/2010
				1987 HILTON STREET		
ALAMANG	E HEALTH CARE CENT	ER		BURLINGTON, NC 27217		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 371	Continued From page	a 6	F 37	1		
1 0/1		tainers with salad, to discard	F 37	At the time of observation	all	
		f cheese in the walk in		unlabeled/dated items wer		
		eleven plastic bags of		discarded (8/8/16). At the	-	
		iscard one dented can in the		observation all cans were		
	dry storage room.			dents and discarded appro	priately	
				(8/8/16). Standing water in	1	
	The findings included	1:		walk-in-refrigerator was co	rrected on	
	0- 0/0/40 -t 0:00 AN			8/8/16.		
		 during the observation of the kitchen, there was 		How corrective action will I		
		ches of standing water on		accomplished for those res		
	the floor.	ches of standing water of		the potential to be affected	-	
				deficient practice.	by the same	
	On 8/8/16 at 6:00 AM	l, during an interview, the		All dining services employe	ees were	
		hat the floor in the walk in		in-serviced regarding sanit		
	cooler needed to be o	dry at any time.		including proper labeling a		
				procedures by dining servi	ces manager.	
		 during the observation of 		Dining services manager a	and employees	
		the kitchen, there were one		were in-serviced on the de	nted can	
		cheese, one plastic bag of		procedure (8/10/16).		
		astic and metal containers		Position job responsibilities	• •	
	with salad observed v	with no labels on it.		sanitation standards, datin		
	On 8/8/16 at 6:05 AM	1, during an interview, the		procedures were reviewed dining services employee I		
		hat all the food in walk in		services manager (8/10/16		
		abeled with expiration date		Dining services manager of		
	and the date of openi	•		problem of standing water		
		-		cleaning with outside vend		
		1, during the observation of		correct process for ensurin		
		the kitchen, there was one		not seep into unwanted are	eas during	
		san cheese, labeled with		cleaning on (8/8/16).		
	expiration data 8/7/16	δ.				
	On 9/9/40 -+ 0:40 AB	L during on interview. the		Measures to be put in plac		
		1, during an interview, the		changes made to ensure p	nactice will not	
		hat all the expired food d from the walk in cooler.		A sanitation inspection aud	lit will be	
				conducted weekly x 4 wee		
	On 8/8/16 at 6.15 AM	1, during the dry food storage		monthly thereafter by Regi		
		ere was one dented can of		ensure compliance with co		

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STATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
		345420	B. WING		C 08/11/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALAMANO	E HEALTH CARE CENT	ER		1987 HILTON STREET BURLINGTON, NC 27217	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETIO
F 371	kitchen cook stated th not be use and neede shelves. On 8/10/16 at 9:50 Al kitchen cook stated th who restocked the sh food labeling. He wa was not labeled in the in cooler. On 8/10/16 at 9:55 Al dietary manager state responsible to keep th bags labeled with cor of opening. All the ex needed to be remove was not aware about walk in cooler and ind cleaning company ha the cleaning. Record review of the revealed the daily, we cleaning assignments for cleaning per kitche assignments were po by the kitchen staff bu storage areas, mentio at the time of observat	auce on the shelf. I, during an interview, the nat all the dented cans could ed to be removed from the M, during an interview, the nat all the kitchen employees ielves, were responsible for s not aware that some food e dry storage room and walk M, during an interview, the ed that all the staff he food in boxes and plastic rect expiration date and date pired food and dented cans ed from the kitchen. She the standing water in the dicated that the floor id to leave the floor dry after kitchen cleaning schedule eekly and monthly kitchen is with AM and PM schedule en areas per shift. All of the sted and marked as done ut the kitchen equipment and oned above, were not clean	F 37	and sanitation standards. A sanitation audit will also be conductly dining services manager at start of business operations following vendor cleaning to ensure proper sanitation to start of daily food service operation. All new hires will receive in-service education regarding proper sanitation standards including dating, labeling discarding dented cans by dining semanager. Any deficient practice identified through the sanitation inspections will result reeducation or disciplinary action as indicated by dining services manager. How facility will monitor corrective action(s) to ensure deficient practice identified through the sanitation is performed at the Qua Quality Assurance meeting x 1 for the and trending for further problem reservices is needed.	of prior prior ons. on and rvices ugh in er. e will arterly acking
	Record review reveal	ed the letter from the			

		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 09/12/2016 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COMF	E SURVEY PLETED
		345420	B. WING			C /11/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANCE HEALTH CARE CENTER 1987 HILTON STREET BURLINGTON, NC 27217						
						1
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 371	last steam cleaning or performed on 8/7/16 a	ompany, indicated that the f floors in the kitchen was and the water absorbent ed to prevent water from	F 37	71		

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