CENTERS F	OR MEDICARE & MEDICAID SERVICES	_		"A" FORM					
STATEMENT C	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY					
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	_ COMPLETE:					
FOR SNFs ANI) NFs	345441	B. WING	10/19/2016					
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, (CITY, STATE, ZIP CODE	•					
ALEXAND	RIA PLACE	1770 OAK HOLL GASTONIA, NC							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	ICIES							
F 159	483.10(c)(2)-(5) FACILITY MANAGE	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS							
	1 -	Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.							
	accounts) that is separate from any of the	The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)							
	The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.								
	The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.								
	The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.								
	The individual financial record must be or his or her legal representative.	The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.							
	account reaches \$200 less than the SSI re the Act; and that, if the amount in the acc	The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.							
	Based on record review, staff and residen	This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interview the facility failed to provide a cognitively intact resident (Resident #25) with a personal funds statement for 1 of 3 sampled residents.							
	The findings included:	The findings included:							
			n 07/04/12 . An annual Minimum Data Set quired set up help only for most activities of						
		An interview was conducted with Business Office Manager on 10/18/16 at 1:37 PM. The Business Office Manager stated the quarterly personal funds account statements were mailed to the address on the chart which							

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

The above isolated deficiencies pose no actual harm to the residents

	MEDICARE & MEDICAID SERVICES		•	A FURIM				
STATEMENT OF IS	OLATED DEFICIENCIES WHICH CAUSE	PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY				
NO HARM WITH O	NLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs AND NF			· · · · · · · · · · · · · · · · · · ·					
		345441	B. WING	10/19/2016				
NAME OF PROVID		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC						
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES							
F 159	Continued From Page 1							
137	was the responsible party. She further stated the	he resident could be given	a a statement if they requested it.					
	During an interview with Resident #25 on 10/19/16 at 8:43 AM the Resident stated she would like to receive a statement of her personal fund account.							
	AM that noted Resident #25 understood the al	orm titled "Policy Regarding Resident Funds" was provided by the Social Worker on 10/19/16 at 11:50 that noted Resident #25 understood the above stated policy and checked that she decided to have a dent fund account. Resident #25 signed the form on 02/14/12.						
	quarterly personal funds account statements to	trator on 10/19/16 at 3:13 PM revealed the facility automatically sent the nt statements to the residents' responsible party. She further stated that the alert eceive a statement of their quarterly personal funds account.						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345441	B. WING _			C 10/19/2016	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		10/13/2010	
(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 ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	5	F O	00			
F 272 SS=D	complaint investigati 483.20(b)(1) COMPR ASSESSMENTS The facility must con	e cited as a result of the on. Event ID#SBZU11. REHENSIVE duct initially and periodically occurate, standardized	F 2	72		11/16/16	
		ment of each resident's					
	assessment of a resiresident assessment by the State. The as least the following: Identification and del Customary routine; Cognitive patterns; Communication;	ident's needs, using the tinstrument (RAI) specified esessment must include at mographic information;					
	Vision; Mood and behavior p Psychosocial well-be Physical functioning Continence; Disease diagnosis at Dental and nutritional Skin conditions;	eing; and structural problems; nd health conditions;					
	Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by th Data Set (MDS); and	immary information regarding sment performed on the care e completion of the Minimum					
AROBATORY		/SLIPPLIER REPRESENTATIVE'S SIGNATUI	DE .	TITLE		(X6) DATE	

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

._

Electronically Signed 11/09/2016

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345441	B. WING		C 10/19/2016
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 770 OAK HOLLOW ROAD GASTONIA, NC 28054	10.10.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 272	Continued From pag	ge 1	F 272		
	by: Based on record red facility failed to complet that addressed the uncontributing factors, mood state, behavior drug use, and dental residents reviewed f	and risk factors related to oral symptoms, psychotropic I care for 8 of 15 sampled or the most recent mum data set (Residents #1,		Plan of Correction Disclaimer Alexandria Place □s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it required by law.	l l
	O2/05/14 with diagnor disorder and schizor disorder and schizor Review of the significant Set (MDS) dated 07. had severely impaired make her needs known MDS also revealed I Level II PASRR (Preceded Resident Review) are serious mental illness MDS noted rejection during the assessment Resident Mood Interfeeling tired 2 to 6 disperiod. The significations	admitted to the facility on oses including depressive		A. Address how corrective action will accomplished for each resident found be affected by the deficient practice: Resident # 1's CAA has been re-work and now addresses the Resident's Mc State, Behavioral Symptoms, and Psychotropic Drug Use in a manner threadily paints a picture of the resident status, talks about the resident's indivicognition, and includes how the trigge areas affected the resident in the anal of findings. Resident # 62 S CAA has been re-worked to address why the resident edentulous status was triggered as a problem, when the resident was last s by the Dentist, and why the resident was not wearing her dentures. The CA also now paints a picture of the resident state.	ed cood nat 's idual cred ysis tus

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION (X3) DATE S G		
			7 50.25	_			c l
		345441	B. WING _			1	/19/2016
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10	713/2010
					770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE				GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIEN	ITATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272	Continued From pag	ne 2	F	272			
	assessment period.	, - <u>-</u>	'-		individual condition, and how the trigge	arad	
	assessment period.				areas affected the resident in the analy		
	a Review of the Ca	are Area Assessment (CAA)			of findings.	7515	
		State dated 08/08/16			3. Resident # 44 □ s CAA has been		
	1	1 had diagnoses including			re-worked to address how the resident	t⊡s	
		lepression and received			psychoactive medications affect the		
		ications and antipsychotic			resident□s day to day living, to addres	S	
	1	red. The CAA Summary			any documentation of adverse reaction		
	indicated Resident #	f1 was alert and verbal most			to the medications, and if any referrals	i	
	of the time but was i	noted with some increased			have been necessary. The CAA also r	IOW	
	· · · · · · · · · · · · · · · · · · ·	tion. It was noted she was			addresses the resident□s strengths ar		
		ed for a urinary tract infection.			weaknesses and how the triggered are	eas	
		referred to a diagnosis list,			affected the resident □s day to day	day	
	physician notes, and				function.		
		ord but did not include dates			4. Resident # 2 s CAA has been		
		ding these documents. The			re-worked to include how the		
	_	ated the data included in the ssessment but the analysis of			psychoactive medications affected the resident s day to day living, any		
		ition Resident #1's Mood			documentation concerning adverse dr	ua	
		riggered area impacted her			reactions, and if any referrals have be	-	
	I .	there had been a change in			necessary. The CAA also now address		
	Resident #1's mood				the resident⊡s strengths and weakness		
					and how the triggered areas affected t		
	b. Review of the CA	AA Summary for Behavioral			resident □s day to day function.		
		/08/16 revealed Resident #1			5. Resident # 15□s CAA has been		
	had diagnoses inclu	ding schizophrenia and			re-worked to include how the resident	∃s	
	depression and was	currently being treated for a			psychoactive drug use affected the		
	urinary tract infection	n. The CAA Summary			resident⊡s day to day living and		
		#1 was noted with some			documentation concerning adverse dr		
		and inattention and had			reactions and if any referrals have bee		
		neals recently. The CAA			necessary. The CAA also now address		
		o a diagnosis list and			the resident □s strengths and weaknes		
	' '	did not include dates or any			and how the triggered areas affected t	ne	
		eses documents. The CAA			resident ☐s day to day function.		
	_	he data included in the			6. Resident # 65 □s CAA has been	20	
	, ,	ssessment but the analysis of			re-worked to include analysis of how the		
	impacted her day to	tion how the triggered area			psychotropic medications affected the resident s day to day function and		
	interventions had be				activities and whether or not they were	د	
	i interventions nau be	on implemented.	1		T GOUVINGS AND WINCHIEF OF HOURINGY WER	,	1

Facility ID: 923196

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
			A. BOILDII	_			С
		345441	B. WING			1	_
NAME OF D	ROVIDER OR SUPPLIER	0.0	<u> </u>	9	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10)/19/2016
NAME OF T	NOVIDEN ON 3011 LIEN				770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE						
					GASTONIA, NC 28054		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272	Continued From no	ogo 2		220			
Γ 2/2	Continued From pa	ige 3	F 2	272			
	5				effective in treating her anxiety and		
		AA Summary for Psychotropic			depression. The CAA also now addres		
		/08/16 revealed Resident #1			the resident s strengths and weaknes		
		uding schizophrenia and			and how the triggered areas affected t	ne	
	· ·	ed antidepressant and cations daily and had an			resident □s day to day function. 7. Resident # 68 □s CAA has been		
		dverse effects from these			re-worked to include analysis of how the	20	
		s noted she was currently			psychotropic medications affected the	ic	
		urinary tract infection. The			resident □s day to day function and		
	_	cated Resident #1 was noted			activities and whether or not they were	ڍ	
	1	cline, some increased lethargy,			effective in treating her anxiety and		
	_	ne CAA Summary referred to a			depression. The CAA also now address	ow addresses weaknesses	
		hysician notes but did not			the resident s strengths and weaknes		
		y details regarding theses			and how the triggered areas affected t		
	documents. The C	AA Summary did not state if			resident is day to day function.		
	the psychotropic m	edications were effective in			8. Resident # 47 □ s CAA has been		
		oms, analyze how the			re-worked to include analysis of how the	те	
		cations affected her day to day			psychotropic medications affected the		
		e if a gradual dose reduction			resident⊡s day to day function and		
		sychotic medication had been			activities and whether or not they were	;	
		AA Summary also did not state			effective in treating her psychosis and		
		ny any adverse drug reactions			depression. The CAA also now addres		
	or if Resident #1 re	ceived psychological services.			the resident s strengths and weaknes		
	An interview was a	andusted with the MDC Nurse			and how the triggered areas affected t	ne	
		onducted with the MDS Nurse 3 PM. The MDS Nurse stated			resident⊡s day to day function.		
		loyed by the facility as the			" Any resident has the potential to b	20	
	1	ears and was responsible for			affected by this practice. A sample of		
	all of the MDS Asse				Resident's CAAs with psychotropic dru		
		IDS Nurse noted she received			use or dental needs will be reviewed. I		
		the Director of Nursing and the			is discovered that the CAAs are not		
		hen she was first hired and			descriptive, another 15 will be reviewe	d.	
		onal MDS training in March of			This review will be conducted by the D		
		he MDS Nurse did not recall			and Administrator and will be complete		
	_	pecifically about CAA			by November 16, 2016.		
		the March training. The MDS			" The DON will review/audit 10 resi	dent	
	Nurse revealed she	e was taught to summarize all			CAAs monthly for 3 months and then		
	the checked blocks	in the MDS assessment when			quarterly for 3 quarters to ensure that		
	completing the ana	lysis of findings for the CAA			each one paints a full picture of the		

STATEMENT OF AND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345441	B. WING		C 10/19/2016
NAME OF PRO	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	10/13/2016
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
S M F T T T T T T T T T T T T T T T T T T	MDS Nurse was not a picture of the resident esident's individual or riggered affected the analysis of findings. 2. Review of the med Resident #62 was addiagnoses including of hemiplegia. Review of the annual 18/28/16 revealed Renaual MDS also note annual MDS also note edentulous and had a Review of the Care Alsummary for Dental Control of the Care Alsummary stated her of the control of the Care Alsummary stated her of the Care Alsummary analysis of the Care Alsummary analysis of the Dentist, or address wearing her dentures an interview was control 10/19/16 at 3:48 Peter had been employ the care and the	diew further revealed the aware she needed to paint a it's status, talk about the condition, or include how the resident when writing the dical record revealed mitted on 10/05/15 with the rebral infarction and discipled infarction and referred to not include dates or any the second discipled infarction and include why the second include dates or any the second discipled infarction and include why the second discipled infarction and include why the second discipled include why the second	F 27	resident and that they fully addres underlying causes, contributing risl factors, and risk factors related to r state, behavioral symptoms, psych drug use, and dental care. Any CA found to not be thorough will be ret to the MDS Coordinator with instru of what areas are lacking and for the tobe re-worked to fix the issue fou audit. Once re-worked, the DON w review the CAA again to ensure completeness. The DON will recorresults of these audits on a QA forr will present the results of the audits next scheduled Weekly Departmen Meeting for review to ensure that the solution is achieved and sustained. The results of the DON is aube presented to the Medical Direct the monthly QA meeting for 3 monta the quarterly QA meetings for 3 of thereafter, for review, to ensure that correction is achieved and is sustained.	mood otropic As curned ctions ne CAA nd on ill d the m and s at the ot Head ne dit will or at ths and quarters t the

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D MANAGE				0
		345441	B. WING			10/	19/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AL EVAND	DIA DI ACE			17	70 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			G/	ASTONIA, NC 28054		
040.15	CLIMMADV C	TATEMENT OF DEFICIENCIES	ID	l	PROVIDER'S PLAN OF CORRECTION		()(5)
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TAG	,	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 272	Continued From pag	e 5	F	272			
		OS Nurse noted she received					
		e Director of Nursing and the					
	_	en she was first hired and					
		nal MDS training in March of					
	_	e MDS Nurse did not recall					
	what she learned spe	-					
	_	e March training. The MDS					
		was taught to summarize all nthe MDS assessment when					
	completing the analy						
	,	view further revealed the					
		aware she needed to paint a					
	·	nt's status, talk about the					
		condition, or include how the					
		e resident when writing the					
	analysis of findings.						
	-	Care dated 09/11/16 was					
		interview and the MDS Nurse					
		es told her Resident #62 did					
	not always wear her	dentures but she did not ask					
	_	e interview Resident #62					
	regarding her denture	es.					
	3. Resident #44 was	s readmitted to the facility on					
		ses including cerebral					
		th left hemiplegia, diabetes					
	mellitus, dementia ar						
	.,	•					
	Review of the annua	l Minimum Data Set (MDS)					

dated 11/09/15 Resident #44 made herself

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION UILDING		TE SURVEY MPLETED
		345441	B. WING			C 1 0/19/2016
	ROVIDER OR SUPPLIER	1 237.0		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		0/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	severely impaired or decision making. Rebehaviors and receiduring the assessment of the second of th	as understood others and had orgnitive skills for daily esident #44 had no negative wed psychoactive medications ent period. Area Assessment (CAA) otropic Drug Use dated he was alert and verbal with Resident #44 had a sision and anxiety and epressant and antianxiety ssessment period. The CAA plan would be developed to dverse effects from a CAA did not include how the ations affected Resident higher had been the experimental exper	F 2	72		
	01/18/16 with diagno	admitted to the facility on oses including diabetes order and depression.				
	Review of the annua	al Minimum Data Set (MDS)				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED	
		345441	B. WING _			C 10/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1770 OAK HOLLOW ROAD GASTONIA, NC 28054	E	10/13/2010
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 272	herself understood was cognitively intal little energy for several assessment period. Resident #2's Care Summary for Psychologory of Psycholo	Area Assessment (CAA) otropic Drug Use dated had a diagnosis of scurrently receiving lication. The CAA also noted adverse effects from se. The CAA did not include we medication affected day living nor was there diverse drug reactions or if any necessary. conducted on 10/19/16 at llurse stated she had been the e years and her most recent in March 2016 in Raleigh with ner. She stated she was not to describe the individual's nesses and how the triggered day to day function.	F 2	72		
	Set (MDS) dated 10 made himself under	#15's annual Minimum Data 0/02/16 revealed he usually estood as well as understood erely impaired cognitive skills				

			OATE SURVEY OMPLETED			
		345441	B. WING			С
	ROVIDER OR SUPPLIER	345441	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		10/19/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	for daily decision mal rejected care for one assessment period. Resident #15's Care Summary for Psycho 10/05/16 noted he ha for which he received medication daily. The at risk for adverse eff use and a care plan vreduce the risk of the did not include how the affected Resident #15 there documentation if any referrals had be During an interview of 3:48 PM the MDS NumDS Nurse for three MDS training was in the State MDS Traine CAA summaries by e boxes in the MDS. Staware she needed to	Area Assessment (CAA) tropic Drug Use dated ad a diagnosis of depression an antidepressant c CAA further noted he was fects from psychotropic drug would be developed to adverse effects. The CAA ne psychoactive medication 5's day to day living nor was of adverse drug reactions or een necessary. onducted on 10/19/16 at arse stated she had been the years and her most recent March 2016 in Raleigh with er. She stated she wrote the laborating on the checked ne further stated she was not describe the individual's esses and how the triggered	F 2	72		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345441	B. WING			C 10/19/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		10/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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)	N SHOULD BE	(X5) COMPLETION DATE
F 272	04/06//16 with diagnor dementia, anxiety, de delusional disorder. Review of the admiss (MDS) dated 05/25/1 was severely cognitive further revealed Resignatipsychotic and an days out of the 7 day received antianxiety 7 day look back perioderical received antianxiety 7 day look back perioderical received antianxiety 8 dated 05/31/16 and 9 Psychotropic Drug U and diagnoses of demes of the CAA did not an amedications as order for adverse effects for The CAA did not an amedications actually function and activities treating her anxiety and 23:48 PM the MDS Number of the MDS Saware she needed to	admitted to the facility on oses of non-Alzheimer's epression, hallucinations and sion Minimum Data Set 6 revealed Resident #65 rely impaired. The MDS dent #65 received tidepressant medication 7 look back period and medication 4 days out of the od. Area Assessment (CAA) written by the MDS Nurse for se stated Resident #65 had intia, depression and anxiety. Intianxiety and antidepressant red. Resident #65 was at risk om psychotropic drug use. Ilyze how the psychotropic affected her day to day is or if they were effective in and depression. Sonducted on 10/19/16 at arese stated she had been the cility for 3 years and her was in March 2016 in the MDS Trainer. She stated yelaborating on the check the further stated she was not a describe the individual's tess and how the triggered	F 27	72		
	7. Resident #68 was	admitted to the facility on				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
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		STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054		1 10/13/2010	
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
09/09/16 with diagnanxiety and depression and any antianxiety, antidepression and any antianxiety, antidepression and any antianxiety, antidepredications as orded adverse effects from CAA did not analyze medications actuall function and activitic treating her anxiety During an interview 3:48 PM the MDS Nurse at the firmost recent training Raleigh with the Stashe wrote her CAA boxes in the MDS. aware she needed strengths and weak areas affected their	sionses of Alzheimer's disease, sion. Sion Minimum Data Set (16 revealed Resident #68 gnitively impaired. The MDS sident #68 received ntianxiety medication 7 days k back period and she sant medication 6 days out of period. Area Assessment dated n by the MDS Nurse for Use stated Resident #68 had mer's disease, dementia, siety. She was receiving ressant and antipsychotic ered. She was at risk for n psychotropic drug use. The e how the psychotropic y affected her day to day es or if they were effective in and depression. conducted on 10/19/16 at Nurse stated she had been the acility for 3 years and her y was in March 2016 in ate MDS Trainer. She stated by elaborating on the check She further stated she was not to describe the individual's eness and how the triggered day to day function.	F 272			
	ROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY O Continued From pa 09/09/16 with diagn anxiety and depress Review of the admi (MDS) dated 09/19, was moderately cog further revealed Re antipsychotic and a out of the 7 day loo received antidepress the 7 day look back Review of the Care 09/22/16 and writte Psychotropic Drug diagnoses of Alzhei depression and anx antianxiety, antidep medications as orde adverse effects from CAA did not analyze medications actuall function and activiti treating her anxiety During an interview 3:48 PM the MDS N MDS Nurse at the fi most recent training Raleigh with the Sta she wrote her CAA boxes in the MDS. S aware she needed strengths and weak areas affected their 8. Resident #47 wa 01/23/15 with diagn	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 09/09/16 with diagnoses of Alzheimer's disease, anxiety and depression. Review of the admission Minimum Data Set (MDS) dated 09/19/16 revealed Resident #68 was moderately cognitively impaired. The MDS further revealed Resident #68 received antipsychotic and antianxiety medication 7 days out of the 7 day look back period and she received antidepressant medication 6 days out of the 7 day look back period. Review of the Care Area Assessment dated 09/22/16 and written by the MDS Nurse for Psychotropic Drug Use stated Resident #68 had diagnoses of Alzheimer's disease, dementia, depression and anxiety. She was receiving antianxiety, antidepressant and antipsychotic medications as ordered. She was at risk for adverse effects from psychotropic drug use. The CAA did not analyze how the psychotropic medications actually affected her day to day function and activities or if they were effective in treating her anxiety and depression. During an interview conducted on 10/19/16 at 3:48 PM the MDS Nurse stated she had been the MDS Nurse at the facility for 3 years and her most recent training was in March 2016 in Raleigh with the State MDS Trainer. She stated she wrote her CAA by elaborating on the check boxes in the MDS. She further stated she was not aware she needed to describe the individual's strengths and weakness and how the triggered areas affected their day to day function. 8. Resident #47 was admitted to the facility on 01/23/15 with diagnoses of non-Alzheimer's	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1770 OAK HOLLOW ROAD GASTONIA, NC 28054 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (REGULATORY OR LSC DENTIFYING INFORMATION) COntinued From page 10 09/09/16 with diagnoses of Alzheimer's disease, anxiety and depression. Review of the admission Minimum Data Set (MDS) dated 09/19/16 revealed Resident #88 was moderately cognitively impaired. The MDS further revealed Resident #86 received antipsychotic and antianxiety medication 7 days out of the 7 day look back period and she received antidepressant medication 6 days out of the 7 day look back period. Review of the Care Area Assessment dated 09/22/16 and written by the MDS Nurse for Psychotropic Drug Uses stated Resident #86 had diagnoses of Alzheimer's disease, dementia, depression and anxiety. She was receiving antianxiety, antidepressant and antipsychotic medications as ordered. She was at risk for adverse effects from psychotropic drug use. The CAA did not analyze how the psychotropic medications actually affected her day to day function and activities or if they were effective in treating her anxiety and depression. During an interview conducted on 10/19/16 at 3:48 PM the MDS Nurse stated she had been the MDS Nurse at the facility for 3 years and her most recent training was in March 2016 in Raleigh with the State MDS Trainer. She stated she wrote her CAA by elaborating on the check boxes in the MDS. She further stated she was not aware she needed to describe the individual's strengths and weakness and how the triggered areas affected their day to day function. 8. Resident #47 was admitted to the facility on 01/23/15 with diagnoses of non-Alzheimer's	

	DF DEFICIENCIES CORRECTION			(X3	(X3) DATE SURVEY COMPLETED	
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F 272	2 Continued From page 11		F 2	272		
	dated 02/03/16 revea moderately cognitivel revealed Resident #4	Minimum Data Set (MDS) led Resident #47 was y impaired. The MDS further 7 received antipsychotic and eation 7 days out of the 7 day				
	dated 02/17/16 and w Psychotropic Drug Us had a diagnoses of di psychosis and anxiet antipsychotic and ant as ordered. She was from psychotropic dru analyze how the psychotropic dru actually affected her of	y. She was receiving idepressant medication daily at risk for adverse effects up use. The CAA did not chotropic medications day to day function and are effective in treating her				
F 278 SS=D	3:48 PM the MDS Nu MDS Nurse at the fact most recent training was Raleigh with the State she wrote her CAA by boxes in the MDS. Shaware she needed to strengths and weakned areas affected their du 483.20(g) - (j) ASSES	e MDS Trainer. She stated y elaborating on the check he further stated she was not describe the individual's less and how the triggered ay to day function.	F 2	278		11/16/16
	The assessment mus resident's status.	t accurately reflect the				
	A registered nurse m	ust conduct or coordinate				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	· '	(X3) DATE SURVEY COMPLETED		
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F 278	assessment is come Each individual who assessment must so that portion of the a Under Medicare an willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin to certify a material resident assessmen penalty of not more assessment. Clinical disagreemen material and false so This REQUIREMEN by: Based on record re facility failed to acc Minimum Data Set	with the appropriate lith professionals. must sign and certify that the pleted. completes a portion of the ign and certify the accuracy of issessment. d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than is sessment; or an individual who gly causes another individual and false statement in a int is subject to a civil money of than \$5,000 for each statement. NT is not met as evidenced eview and staff interview, the curately code information on an iregarding falls for 1 of 4 reviewed for falls (Resident)	F 2'	Alexandria Place s response to a survey report does not constitute agreement with the statement of deficiencies; nor does it constitute admission that any stated deficien accurate. We are submitting the F because it is required by law.	e an ncy is		
	Resident #69 was a	admitted on 05/26/16 with g dementia, muscle weakness,		A. Address how corrective action accomplished for each resident for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE			
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ALEXANDRIA PLACE			GASTONIA, NC 28054			
PREFIX (EACH DEFI	ARY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
(MDS) dated 06 severely impairs make her needs further revealed assistance with only once or twin room or the corn Resident #69 hat to the facility. Review of a fall #69 was found of 07/07/16 at 6:45 was standing an had fallen. Review of the quarterly MDS in extensive assist and walking in hindicated Reside admission to the During an interv MDS Nurse stat falls during morn meeting. The Most completed Reside 08/25/16 and shassessment to in The MDS Nurse how she missed	dmission Minimum Data Set //02/16 revealed Resident #69 had ed cognition and was able to a known. The admission MDS Resident #69 required extensive bed mobility, transfer occurred ce, and she did not walk in her ridor. The admission MDS noted and no falls prior to her admission investigation revealed Resident on the floor in her room on a PM. Resident #69 told staff she and trying to turn down her bed and cuarterly MDS dated 08/25/16 and #69 was cognitively intact and the her needs known. The aloted Resident #69 required ance with bed mobility, transfer, her room. The quarterly MDS and #69 had no falls since her	F 27	be affected by the deficient prace Resident # 69 s MDS has been to include the fall from 07/07/20 was missed on the 08/25/2016 B. Address how corrective actic accomplished for those residen potential to be affected by the sideficient practice: "Any resident has the potent affected by this practice. The Miresidents having had falls within 90 days have been reviewed ar were correctly coded on those of the MDS Coordinator will now report from the Weekly Fall Cormitted MDS any and all falls that he occurred during the period that addressed by the MDS when continued the section on falls. The DON were review/audit all MDS so findivinave had falls to ensure that the Coordinator has accurately caping falls and has not missed one in the DON will document the residence or systemic changes made ensure that the deficient practic occur. C. Address what measures will place or systemic changes made ensure that the deficient practic occur. The MDS Coordinator will the report from the Weekly Fall Committee Meeting to ensure the captures on the MDS any and a	n updated of that MDS. on will be ats having a same of the last and all falls MDS so use the mittee tures on lave is completing will add that the future. Sults of this of this of this of the months of the future of the future of the future of the future. Sults of this of this of this of the months of the will not the future of the f		

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F 278	Continued From pag	e 14	F 2	have occurred during the addressed by the MDS w the section on falls. The D review/audit all MDS on have had falls monthly for ensure that the MDS Coo accurately captured all fall missed one in the future. document the results of the on a QA form and will preat the next scheduled We Head Meeting for one year ensure that the solution is sustained. D. Indicate how the facility monitor the measures to a solutions are sustained. The plan must be implement corrections are achieved. The plan must be implement corrective action evaluate effectiveness. The POC in integrated into the Quality system of the facility. "The MDS Coordinated the report from the Weekl Committee Meeting to encaptures on the MDS any have occurred during the addressed by the MDS we the section on falls. The D review/audit all MDS on have had falls monthly for ensure that the MDS Coordinated the model that the MDS coordinated that the MDS coo	when completing DON will of individuals the rone year to ordinator has alls and has not the DON will his review/audiesent the result each per view to a achieved and sustained and the ed for its must be a Assurance or will now use by Fall sure that she and all falls the period that is when completing DON will of individuals the ordinator has alls and has not sustained and sustained and sustained and sustained and sustained and the ed for its must be a facility facilit	at t sent t st

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040.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES			·		0/5)
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F 278 F 371 SS=E	Continued From page 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food from	oCURE,		371	document the results of this review/aud on a QA form and will present the result at the next scheduled Weekly Departm Head Meeting for one year for review to ensure that the solution is achieved and sustained. Additionally, the results of th DON s monthly audit will be presented the Medical Director at the Quarterly Queeting for one year for review to ensuthat the correction is achieved and is sustained.	ts ent o d d ne d to A	11/16/16
	considered satisfacto authorities; and (2) Store, prepare, dis under sanitary condition of the condition of	etribute and serve food sons is not met as evidenced ns and staff interviews the ain the kitchen ice machine condition and air dry plastic e stacking in storage.			Alexandria Place □s response to this survey report does not constitute agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are submitting the POC because it required by law.		
	initial tour of the kitch revealed the interior of	e ice machine during the en on 10/16/16 at 9:51 AM of the ice bin had an angled (ice deflector) mounted at			A. Address how corrective action will be	oe	

PRINTED: 11/21/2016 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	
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ALEXAND	ORIA PLACE			GASTONIA, NC 28054		
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F 371	Continued From page	e 16	F 3	71		
	across the entire top down approximately	The ice deflector extended of the ice bin and extended inches. A thin film of the entire surface of the		accomplished for each resident be affected by the deficient prac		
	ice deflector as well. wiped across the surf black matter came of	A white paper towel was face of the ice deflector and f on to the paper towel.		" 1. The ice machine in the ki thoroughly cleaned by the Dietal Manager and the Maintenance S on the morning of 10/16/2016 af	ry Supervisor ter	
	Manager (DM) on 10/ stated cleaning the in	rview was conducted with the Dietary er (DM) on 10/16/16 at 10:04 AM. The DM cleaning the interior of the ice bin was not cleaning schedule but she had observed		discussion with the surveyor not need for cleaning. Additionally, t company contracted to provide of cleaning of the ice machine arriv	he quarterly ved at the	
	the dietary aides wiping it down regularly. The DM observed while a white paper towel was wiped across the surface of the ice deflector and			facility and performed a thorough 10/17/2016. The service tech als the Dietary Manager and the	so showed aintenance	
	DM stated the interior	f on to the paper towel. The r of the ice machine would acluding the ice deflector.		Supervisor how to properly clear inside of the ice machine includi deflector. 2. The Dietary Manager immedia	ng the ice	
		erview on 10/16/16 at 10:06 e ice machine was cleaned geration contractor on		removed the bowls and glasses noted by the Surveyor to not be had these items rewashed/saniti	that were dry and	
	three months. The D know how the black r the ice deflector. The	ere contracted to come every M indicated she did not natter had accumulated on e DM further stated she		properly set out for air drying as by regulation. The Dietary Mana spoke to the staff member that v responsible for stacking the wet	ger also vas items at	
	they would decide wh			that time and reiterated the impo- allowing the items to fully air dry stacking.		
	Administrator stated the kitchen ice machi was not acceptable. refrigeration contractor	n 10/17/16 at 12:30 PM the the condition of the interior of ne observed on 10/16/16 The Administrator noted the pr had been out earlier that serviced the ice machine.		B. Address how corrective action accomplished for those resident potential to be affected by the sa deficient practice.	s having a	
	I .	tary Aide #1 on 10/18/16 at ne was never instructed to e ice machine.		All dietary staff will be in servi proper way to check and clean t machine. The dietary manager a	he ice	

Facility ID: 923196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1770 OAK HOLLOW ROAD GASTONIA, NC 28054	CODE	10/13/2010
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F 371	Dietary Aide #2 stat anything with the ice outside. 2. Observations of 10/16/16 at 9:18 Alvert stored on a tray face inside of all 14 bowl stacks of five clear proted in the top 4 ce During an interview DM stated the dieta dry all kitchenware in before placing them. The DM observed the storage rack and state been stacked until the placed on the storage outside in the best orage.	on 10/18/16 at 2:36 PM ed she was not trained to do e machine except wipe of the a kitchen storage rack on for revealed 14 plastic bowls e down with moisture noted s. In addition, there were 2 plastic cups with moisture ups in each of the two stacks. on 10/16/16 at 10:09 AM the ry aides were expected to air ncluding bowls and cups on the storage rack for use. The bowls and cups on the ated they should not have they were dry inside. She was owls and cups had been ge rack. The DM removed the in the storage rack and placed	F3	maintenance supervisor has erviced by the contract of company on how to disass thoroughly clean the ice most staff will conduct daily checleaning on the ice machindietary manager and main supervisor will disassemble thoroughly clean the ice most weeks. The dietary managed designee will conduct daily ice machine for cleanlines results of all cleaning scherecorded. These daily cheched weeks and then will be contained to make a service or a seeks monthly for one year. The cleaning will be done for or results of all QA checks are be recorded on a QA form 2. Any resident has the post affected by this practice. A will be in serviced on the post and dry all dinnerwal items cannot be stacked undry. The Dietary Manager designee will conduct daily dinnerware following the witems to ensure that no dir being stacked before being dry. These daily checks will weeks and will then be contained to the contained that the deficient proccur. C. Address what measure place or systemic changes ensure that the deficient proccur.	eaning semble and nachine. Dietary cks and ne and the stenance e and nachine every 2 ger and or her y checks of the s and the edules will be cks will last for conducted on a and then bi-weekly ne year. The nd cleanings will tential to be all Dietary Staff proper way to re and why and/or her y checks of all vashing of these nerware is g completely ill last for 3 nducted on a s and then	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
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F 371	Continued From pag	e 18	F3	371			
				1.All dietary staff will be proper way to check and machine. The dietary m maintenance supervisor serviced by the contract company on how to disa thoroughly clean the ice staff will conduct daily c cleaning on the ice machine dietary manager and masupervisor will disassem thoroughly clean the ice weeks. The dietary manadesignee will conduct doice machine for cleanling results of all cleaning so recorded. These daily conduct doine machine for one year. The cleaning will be done for results of all QA checks be recorded on a QA for these checks will be preweekly department head review to ensure that the achieved. 2.All Dietary Staff will be the proper way to wash dinnerware and why iter stacked until completely Manager and/or her designees was a completely manager and was a completely manager and was a completely manager and was a completel	d clean the ice nanager and r have been in t cleaning assemble and e machine. Dieta checks and chine and the aintenance mble and e machine every nager and or her laily checks of the checks will last for e conducted on eks and then the bi-weekly or one year. The sand cleanings or one year. The sand cleanings or one year and or her laily checks will last for e conducted on eks and then the bi-weekly or one year. The sand cleanings or one year is and cleanings or one year. The sand cleanings or one year is and cleaning for her solution is e in serviced on and dry all ms can not be year. The Dieta signee will conditions and the properties of the properties	ry will of	

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, (22)				GASTONIA, NC 28054		
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F 371	Continued From page	e 19	F3	no dinnerware is bei being completely dry will last for 3 weeks conducted on a rand weeks and then mor results of these ched on a QA form. The Depresent the results of the Weekly Department review to ensure the achieved. D. Indicate how the monitor the measure solutions are sustain develop a plan for electrician are achieved. The plan must be imcorrective action evaluation effectiveness. The Plantegrated into the Questern of the facility 1. All dietary staff will proper way to check machine. The dietary maintenance supervised by the conticompany on how to thoroughly clean the staff will conduct daic cleaning on the ice of dietary manager and supervisor will disast thoroughly clean the weeks. The dietary redesignee will conduct designee will designee w	y. These daily check and will then be dom bases for 3 onthly for 1 year. The cks will be recorded dietary Manager with these QA checks and Head Meeting at the solution is facility plans to the set of make sure the end. The facility munsuring that the eved and sustained applemented and the aluated for its POC must be quality Assurance of the end of th	e d III s at for at ust d. e the ary

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		l\ '	(X3) DATE SURVEY COMPLETED			
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ALEXAND	ORIA PLACE			GASTONIA, NC 28054		
	OUR MAN DV OT	ATTIMENT OF REFIGIENCIES				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 371	Continued From page	e 20	F 3		be st for on a The gs will ults of the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
						С
		345441	B. WING _			10/19/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=	
				1770 OAK HOLLOW ROAD		
ALEXAND	RIA PLACE			GASTONIA, NC 28054		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		
F 371	Continued From page	e 21	F3	QA committee meeting and pr		
				and reviewed to the medical d the quarterly QA meeting for re ensure that the solution is ach	eview to	
				sustained. The QA checks will	I continue	
				be reviewed by the QA commi		
				time period of one year and the as determined by the interdisc		g
				team.	лрина у	