	-	D HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			(	OMB NC	<u>). 0938-0391</u>
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		LETED
		345419	B. WING				C 01/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				17	CORNELIA DRIVE		
LEXINGTO	ON HEALTH CARE CENT	ER		L	EXINGTON, NC 27292		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282 SS=D	PERSONS/PER CAR (b)(3) Comprehensive The services provided	E PLAN	F 2	282			6/16/17
	<ul> <li>(ii) Be provided by quaccordance with each care.</li> <li>This REQUIREMENT by:</li> <li>Based on observation review the facility failed on the care plan and resident (Resident #1 nothing by mouth.</li> <li>The findings included</li> <li>Resident #1 was origin on 4/27/17, discharger and then readmitted the Resident #1 had the findings disorder// (left sided weakness) cognitive impairment. most recent compreh (MDS) assessment, and dated 5/4/17, reveale maximum assistance bed mobility, was tota person for eating, and two or more people for the 5/4/16 MDS assessment</li> </ul>	n resident's written plan of is not met as evidenced is not met as evidenced is not met as evidenced is not met as evidenced in, staff interview, and record is do follow an intervention Kardex, for one of one ) who was to receive ) who was			The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state ar federal regulations as outlined. To remain compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction. The following plan of corrective action will be completed by the dates indicated. F282 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Resident #1 care plan was accurate with NPO care plan in place.	nd ain g f	
	receiving nutrition and tube.	d hydration via a feeding			(DON)/Unit Manager or designee reviewed/updated all NPO care plans for	or	
LABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE

Electronically Signed

(X6) DATE 06/15/2017

PRINTED: 07/05/2017

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	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-03 ATE SURVEY		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	Ć	OMPLETED		
						С		
		345419	B. WING			06/01/2017		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E			
LEXINGTO	ON HEALTH CARE CENT	TER		17 CORNELIA DRIVE LEXINGTON, NC 27292				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIO		
F 282	Continued From page	e 1	F 28	32				
				current interventions on 6/5/1	7. Nurses			
		1's Care Plan with a last		and certified nursing assistan	. ,			
		7 revealed a focus area that		received education on following				
		s an Activities of Daily Living		plan interventions related to N				
		rmance deficit related to Disease Process, Stroke,		6/9/17 and completed 6/15/1 Development Coordinator (SE				
		e goal listed was for the		current nurses or CNAs on lea	,			
		urrent level of function		and all staff received training				
		ate. The intervention listed		returning to work.				
		e resident was nothing by						
	. ,	is on tube feedings. This		F282 Measures to be put in p				
		intervention had a created		systemic changes made to er				
	date and a revision o	n date of 4/28/17.		practice will not re-occur: Ne				
	Deview of Desident #	tila physician's orders		and CNAs will receive educat				
		*1's physician's orders ted 5/25/17, at the time of		following the care plan interve related to NPO status during				
		eceive any food or drink		The DON/Unit Manager or de				
	orally.			interview 5 CNAs weekly on c	-			
				kardex interventions, then twi	•			
	An interview that was	s conducted with Nurse #1 on		2 months (began 6/9/17 and v	vill complete			
		revealed she was Resident		August 2017). Any deficient p	practice will			
	-	Nurse #1 provided the		result in re-education and/or o	lisciplinary			
		dent #1 had a feeding tube		action as needed.				
		g, was nothing by mouth,						
	-	s, the resident was not dition, Nurse #1 stated		F282 How facility will monitor	corrective			
		npletely paralyzed on her left		action(s) to ensure deficient p				
		iximum assistance for		not re-occur: Results of the w				
		ing, such as transfers, and		will be reviewed at Weekly Ri	•			
	mobility.	-		Assurance Meeting x 3 month	is and			
				Quarterly Quality Assurance r				
		s conducted with Nursing		for further resolution if needed	J.			
	Assistant (NA) #1 on							
		en assigned to Resident #1		Date of compliance: June 16	2017			
		NA #1 stated that normally on her assignment but was		Date of compliance: June 16	, 2017			
		aware that Resident #1						
	-	n and nutrition through the						
		t she did not receive meal						

Facility ID: 923306

If continuation sheet Page 2 of 12

					FORM	MAPPROVED		
IES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE			
	345419	B. WING				C / <b>01/2017</b>		
SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
				17 CORNELIA DRIVE				
CARE CENT	EK			LEXINGTON, NC 27292				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOULD F	ЗE	(X5) COMPLETION DATE		
d From page vation of Re revealed R her wheelch bed tray tabl s a feeding ainer of form us (IV) pole. and running. g sitting on reach that that appea had her call he call light staff membe vas asked if responded, " d by NA #1 a vas asked b The reside g for her dry he resident p nk. When the 1:57 AM witt the NAs we b. The NAs we he aware the the NAs we had a coffee rom it. NA #2 wo ormation rege and reveale ed 5/25/17 t f the NAs we	e 2 sident #1 on 5/31/17 at esident #1 to be sitting in her air at the bedside with the e positioned in front of her. tube present, with a pump, nula hanging on an . The pump was observed . Resident #1 had a black the table in front of her was approximately half full red to be coffee. The light in her hand and button at 11:53 AM. There rs in the room and when the she needed something, the 'no." The call light was and NA #2 at 11:55 AM. The y the NAs if she needed nt responded she wanted mouth. The NAs left the bicked up the coffee cup and he two NAs returned to the the mouth swabs for the re questioned if Resident #1 responded that neither of resident was nothing by the made aware that the cup and had been observed #1 stayed in the room with went out of the room to garding the resident's dietary ed to the resident's dietary ed to the resident was NPO. ere able to provide an			DEFICIENCY)				
	EDICARE & DICARE & DICARE CENT SUPPLIER I CARE CENT SUMMARY ST ACH DEFICIENC GULATORY OR I CARE CENT I CARE CENT SUMMARY ST ACH DEFICIENC GULATORY OR I CARE CENT I	IDENTIFICATION NUMBER: 345419 SUPPLIER I CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL	EDICARE & MEDICAID SERVICES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MUL         IDENTIFICATION NUMBER:       A BUILD         345419       B. WING         SUPPLIER       ICARE CENTER         ICARE CENTER       IDENTIFICATION NUMBER:       ID         SUMMARY STATEMENT OF DEFICIENCIES (SUPPLIER       ID         ICARE CENTER       ID       PREF         SULATORY OR LSC IDENTIFYING INFORMATION)       PREF         d From page 2       F         vation of Resident #1 on 5/31/17 at       Prevealed Resident #1 to be sitting in her         her wheelchair at the bedside with the       bed tray table positioned in front of her.         is a feeding tube present, with a pump,       ainer of formula hanging on an         usus (IV) pole. The pump was observed       and running. Resident #1 had a black         ug sitting on the table in front of her       r reach that was approximately half full         d that appeared to be coffee. The       had her call light button at 11:53 AM. There         staff members in the room and when the       was asked if she needed         The resident responded she wanted       g for her dry mouth. The NAs left the         he resident picked up the coffee cup and       ink. When the two NAs returned to the         11:57 AM with mouth swabs for the       the NAs were questioned if Resident #1	EDICARE & MEDICAID SERVICES         DIES         IX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         A BUILDING         345419         B. WING         SUPPLIER         ICARE CENTER         SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)         d From page 2         revealed Resident #1 on 5/31/17 at I revealed Resident #1 to be sitting in her her wheelchair at the bedside with the bed tray table positioned in front of her. Is a feeding tube present, with a pump, ainer of formula hanging on an usg (IV) pole. The pump was observed and running. Resident #1 had a black ug sitting on the table in front of her r reach that was approximately half full d that appeared to be coffee. The had her call light in her hand and the call light button at 11:53 AM. There staff members in the room and when the was asked by the NAs if she needed The resident responded she wanted g for her dry mouth. The NAs left the her resident picked up the coffee cup and ink. When the two NAs returned to the 11:57 AM with mouth swabs for the the NAs were questioned if Resident #1 0. The NAs responded that neither of re aware the resident was nothing by The NAs were made aware that the had a coffee cup and had been observed from it. NA #1 stayed in the room to formation regarding the resident's dietary IA #2 returned to the resident's norm at 1 and revealed that the resident was NPO. I the NAs were able to provide an on as to how the resident had received	EDICARE & MEDICAID SERVICES         DES       (11) PROVIDER/SUPPLER/LIA         JUDENTFICATION NUMBER:       A BUILDING         JUDENTFICATION NUMBER:       A BUILDING         SUPPLIER       STREET ADDRESS, CITY, STATE, 2IP CODE         I CARE CENTER       ITECARDONELLA DRIVE         SUMMARY STATEMENT OF DEFICIENCIES       ID         ORDEPCIENCY       ID         SUMMARY STATEMENT OF DEFICIENCIES       ID         ORDEPCIENCY       ID         SUMARY STATEMENT OF DEFICIENCIES       ID         ORDEPCIENCY MUST BE PRECEDED BY FULL       CROSS-REFERENCED TO THE APPORT         SULTORY OR LSC IDENTIFYING INFORMATION)       PRETX         Vation of Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 to be sitting in her       PRETX         Irevealed Resident #1 had a black       I	HEALTH AND HUMAN SERVICES     FOR       DICARE & MEDICAID SERVICES     OMB NX       SUPPLIER     (x1) REOVIDERISUPPLIENCUA IDENTIFICATION NUMBER     (x2) MULTIPLE CONSTRUCTION A BUILDING     (x3) DATE COME       SUPPLIER     ISTREET ADDRESS, CITY, STATE, ZP CODE     (x3) DATE COME     (x4) DATE       SUPPLIER     ICARE CENTER     STREET ADDRESS, CITY, STATE, ZP CODE     (x4) DATE       SUMMER'S STREENT OF DEFICIENCES     INFORMATION, NC 27232     DATE       SUMMER'S STREENT OF DEFICIENCES     PRETRY     ROOSSREETENEY       SUMMER'S STREENT OF DESCRIPTION OF DEFICIENCES     PRETRY     ROOSSREETENEY       SUMMER'S VALUES     PRETRY     ROOSSREETENEY     DEFICIENCY       d From page 2     F 282     F 282     F 282       valion of Resident #1 no 5/31/17 at Irevelated Resident #1 a back ag streing the present, with a pump, ainer of formula hanging on an us (V) pole. The pump was observed and running. Resident #1 had a black ag streing the resident had a black     F 282       Valia of UNA #1 and NA #2 at 11:55 AM. The was asked by NA #2 at 11:55 AM. The was asked by NA #3 at 155 AM. The was asked by NA #3 at 155 AM. The was asked b		

Facility ID: 923306

If continuation sheet Page 3 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345419	B. WING				C 101/2017	
NAME OF PF	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 282	8:55 AM NA #1 revea if a resident was NPC and the resident's nur communicate that a re mouth. NA #1 express resident had a feeding nothing by mouth. N/ had been printed out was in transition thou paperless system. No paper care guide for F aware how Resident a cup. NA #1 stated mo aware that Resident # had been the first time with something to drift that she had not seen first entered the room 5/31/17. When she re #2 she became aware coffee cup and then the In an interview that we 6/1/17 at 9:32 AM rev facility used to have of on a paper copy, but NA #3 logged into her monitor and was able information that was a Electronic Medical Re stated if she needed i able to log into the EN information from the F	NAs. cted with NA #1 on 6/1/17 at led she was able to identify by checking the care guide rese would also verbally esident was nothing by used she was aware if a g tube the resident may be A#1 stated the care guides for the NAs. The facility gh and was going to a A #1 was unable to locate a Resident #1. NA #1 was not #1 had received the coffee to the facility staff were #1 was NPO and that this e she had seen Resident #1 hk. NA #1 further clarified to answer the call light on eturned to the room with NA e that the resident had the he coffee cup was removed. as conducted with NA #3 on realed NA #3 stated the tare guides for the residents now everything was online. account on a wall mounted to show resident available to the NAs in the ecord (EMR) system. NA#3 information she would be MR and obtain the Kardex. She stated the e document that provided	F	282				
	resident care information the NAs to review.	tion and was available for						

Facility ID: 923306

If continuation sheet Page 4 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/05/2017 // APPROVED ). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION		LETED
		345419	B. WING				C 01/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	7 CORNELIA DRIVE		
	ON HEALTH CARE CENT	ER		L	EXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		E	COMPLETION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE
					DEFICIENCY)		
F 282	Continued From page	2 4	F	282			
		cted with NA #1 on 6/1/17 at					
		ed that resident nutrition able through the EMR on					
		emonstrated how to access					
		. A review of Resident #1's					
		Resident #1 had information					
	under the interventior	n for Eating/Nutrition that					
		was NPO and was on a					
	feeding tube. NA #1	acknowledged that the					
	Resident #1's Kardex	provided information that					
	Resident #1 was noth	ing by mouth.					
	An interview conducte	ed with the Director of					
		1/17 at 11:56 AM revealed					
		be for an NA to review the					
	Kardex to familiarize						
		n their assignment. If the					
		out the care to be provided,					
	the NA could refer ba	ck to the Kardex or consult					
	the nurse. The DON	further clarified that by					
	•	's nothing by mouth status					
		area it will trigger for the					
		tus to be carried over to the					
		viewed Resident 1's care					
	•	hat it was care planned that					
		<ol> <li>The DON reviewed and confirmed that the</li> </ol>					
		othing by mouth was under trategies. The DON stated					
		ding Resident #1 being					
		s available to the NAs. The					
		at an active investigation					
	was ongoing in an eff						
		ived the cup of coffee.					
	An interview that was						
		17 at 12:53 PM revealed his					
	expectation was for a	n NA to review the Kardex					

Facility ID: 923306

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 07/05/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345419	B. WING		C 06/01/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
	ON HEALTH CARE CENT	FR		17 CORNELIA DRIVE	
LEXING	SA HEALIN GARE GEN			LEXINGTON, NC 27292	
(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 SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 282	Continued From page	5	F 28	22	
	to familiarize themsel were on their assignm question about the ty could refer back to th	ves with the residents who	1 20		
F 323 SS=D	nurse. 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI	-(3) FREE OF ACCIDENT SION/DEVICES	F 32	23	6/16/17
	(d) Accidents. The facility must ensu	ure that -			
	(1) The resident envir from accident hazard	ronment remains as free s as is possible; and			
		eives adequate supervision es to prevent accidents.			
	appropriate alternativ bed rail. If a bed or s must ensure correct i	facility must attempt to use es prior to installing a side or ide rail is used, the facility nstallation, use, and rails, including but not limited			
	to the following eleme	-			
	(1) Assess the reside from bed rails prior to	nt for risk of entrapment installation.			
		and benefits of bed rails with nt representative and obtain or to installation.			
	This REQUIREMENT by:	sident's size and weight.			
	review the facility faile	n, staff interview, and record ed to provide supervision to m consuming liquids for one		F323 How corrective action will be accomplished for each resident fou have been affected by the deficien	und to
<u> </u>					

Facility ID: 923306

If continuation sheet Page 6 of 12

			0.00			10.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · · ·	TE SURVEY MPLETED
			A. BUILDING	3		
		345419	B. WING			C
	ROVIDER OR SUPPLIER	545415		STREET ADDRESS, CITY, STATE		6/01/2017
NAME OF P	ROVIDER OR SUPPLIER				E, ZIP CODE	
LEXINGTO	ON HEALTH CARE CEN	TER		17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PI	AN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	COMPLETIO
F 323	Continued From pag	e 6	F 32	23		
		dent #1) who was to receive		practice: Resident #1	1 had coffee	
	no food or drink by m			removed from room a		
				MD was notified of in	•	
	The findings included	d:		adverse outcome from noted.	n non-compliance	
	Resident #1 was orig	inally admitted to the facility				
		ed to the hospital on 5/22/17,		F323 How corrective	action will be	
	and then readmitted	to the facility on 5/25/17.		accomplished for those	se residents having	
	Resident #1 had the	following diagnoses:		the potential to be aff		
	Gastrostomy (feeding			deficient practice: Th	÷	
	· •	/impairment), Hemiplegia		(DON)/Unit Manager		
		) following a stroke, and		all NPO patients to er		
		. Review of Resident #1's		interventions are in pl		
		nensive Minimum Data Set an admission assessment		06/05/17). Any interv will involve staff re-ed		
		ed Resident #1 required		practice continues, th		
		e of two or more people for		disciplinary action. Al		
		ally dependent on one		assistants (CNAs) red	-	
		d was totally dependent on		NPO status and wher		
		or transferring. According to		Kardex (began 6/9/17		
		essment Resident #1 had		6/14/17) by Staff Dev		
	severely impaired co	gnition and was coded as		Coordinator (SDC). C	Dngoing education for	
	receiving nutrition an	d hydration via a feeding		orientation and as ne	eded by SDC/DON	
	tube.			or designee. No curr		
				on leave or FMLA and		
		1's Care Plan with a last		training prior to return	ning to work.	
		7 revealed a focus area that				
	read, the resident ha			F323 Measures to be		
	performance deficit r	-		systemic changes ma		
		Process, Stroke, and		practice will not re-oc	•	
		al listed was for the resident		staff will continue to r		
	-	vel of function through the ervention listed for eating		NPO status and how during orientation (on		
		was nothing by mouth		orientation and as ne		
		eedings. This focus area,		or designee). Audits	-	
		n had a created on date and		NPO residents to ass		
	a revision on date of			liquids at bedside we		
		0,		monthly x 2 (began 6)	-	
		#1's physician's orders			designee.	

Facility ID: 923306

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/05/2017 MAPPROVED D. 0938-0391
STATEMENT O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345419	B. WING				C /01/2017
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	N HEALTH CARE CENT	ED		17	7 CORNELIA DRIVE		
LEXINGIC	IN HEALTH CARE CENT	ER		L	EXINGTON, NC 27292		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	readmission, to not re orally. Review of Resident # Pathology Evaluation dated 5/26/17 revealed identified as at risk for indicated Resident #1 and symptoms of dys was documented that awareness of food or need to swallow. The during the evaluation impairments, associa for aspiration, further increased dependency recommendations fro that the resident not e mouth. An interview that was 5/31/17 at 11:23 AM of #1's assigned nurse. information that Resid for continuous feeding (NPO), and due cogn not interviewable. In Resident #1 was com side and required ma Activities of Daily Livi mobility. An interview that was Assistant (NA) #1 on revealed she had bee for day shift that day.	ted 5/25/17, at the time of eceive any food or drink and Plan of Treatment ed Resident #1 was r aspiration. The evaluation had severe clinical signs phagia with thin liquids. It is the resident had no drink in her mouth or the erisk factors identified included: physical ted functional deficits, at risk decline in function, and ey on caregivers. The m the evaluation included eat or drink anything by conducted with Nurse #1 on revealed she was Resident Nurse #1 provided the dent #1 had a feeding tube g, was nothing by mouth itive loss, the resident was addition, Nurse #1 stated upletely paralyzed on her left ximum assistance for ng, such as transfers, and conducted with Nursing 5/31/17 at 11:34 AM en assigned to Resident #1 NA #1 stated that normally	F	323	F323 How facility will monitor correcti action(s) to ensure deficient practice of not re-occur: Results of the weekly au will be reviewed at Weekly Risk Quali Assurance Meeting x 3 months and Quarterly Quality Assurance meeting for further resolution if needed. Date of compliance: June, 16, 2017	will ıdits ty	
	revealed she had bee for day shift that day. Resident #1 was not	en assigned to Resident #1					

Facility ID: 923306

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		MEDICAID SERVICES					NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTR		· · · ·	TE SURVEY MPLETED	
			A. BUILDIN	NG				
		245440	B. WING				С	
		345419	B. WING _				6/01/2017	
NAME OF PI	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	PCODE		
LEXINGTO	ON HEALTH CARE CEN	TER						
				LEXINGT	TON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 323	Continued From pag	ie 8	F 3	323				
	· · · · · · · · · · · · · · · · ·	ended Speech Therapy (ST)		,20				
t		en had Occupational Therapy						
		#1 was aware that Resident						
		ation and nutrition through						
		I that she did not receive						
	-	lso stated Resident #1 had						
	returned from therap	y and was sitting in her						
	room.							
		esident #1 on 5/31/17 at						
		Resident #1 to be sitting in her						
		hair at the bedside with the						
	-	ble positioned in front of her.						
		tube present, with a pump,						
	and container of form							
		e. The pump was observed g. Resident #1 had a black						
	-	the table in front of her						
		was approximately half full						
		ared to be coffee. The						
		light in her hand and						
		button at 11:53 AM. There						
		ers in the room and when the						
		f she needed something, the						
	resident responded,	"no." The call light was						
		and NA #2 at 11:55 AM. The						
	resident was asked b	by the NAs if she needed						
		ent responded she wanted						
		y mouth. The NAs left the						
		picked up the coffee cup and						
		the two NAs returned to the						
		ith mouth swabs for the						
		ere questioned if Resident #1						
		th. The NAs responded that						
		aware the resident was						
		e made aware that the						
	resident had a coffee cup and had been observed drinking from it. NA #1 stayed in the room with							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COMF	
		345419	B. WING				01/2017
NAME OF P	ROVIDER OR SUPPLIER	L	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1	
LEXINGTO	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 323	obtain information reg status. NA #2 returned 12:01 PM and revealed order dated 5/25/17 th Neither of the NAs we explanation as to how the coffee cup. The of from the room by the Another interview was on 5/31/17 at 12:03 P Resident #1 was NPO explained that she ha Resident #1 had a co drinking from it. Nurs know how Resident # cup. An interview that was Therapist (ST), on 5/3 that she had been wo the morning. Through was discovered that se #1 the coffee cup. Th because of the reside and high risk for aspir with the resident she pieces of ice chips as stated Resident #1 di pieces of ice chips bu resident was safe at the liberalized diet, include foods. In an interview with N PM, she stated Reside had given her the coff there was no staff me	adding the resident's dietary ad to the resident's room at the that the resident had an that the resident was NPO. The resident had received coffee cup was removed NAs. Is conducted with Nurse #1, PM. Nurse #1 confirmed that D. Nurse #1 further the been informed that ffee cup and was observed the #1 stated she did not the had obtained the coffee conducted with the Speech additional the coffee conducted with the Speech additional the coffee the ST further clarified ent's nothing by mouth status ration that when she worked had only given her two to a therapeutic trial. The ST d well with the pieces of two	F	32:			

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	-					FORM	APPROVED
							0.0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		LE CONSTRUCTION	(X3) DATE COMP	SURVEY
-			A. BUILD	ING			
		345419	B. WING				
	ROVIDER OR SUPPLIER	040410			STREET ADDRESS, CITY, STATE, ZIP CODE	06/	01/2017
NAME OF PI	ROVIDER OR SUPPLIER						
LEXINGTO	ON HEALTH CARE CENT	ER					
					LEXINGTON, NC 27292		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
140				DEFICIENCY)			
F 323	Continued From page	10		323			
1 525	· · · · · · · · · · · · · · · · ·		F	323	S		
	•	ned [Person #1]. Nurse #1					
		n discovered Resident #1					
	had asked for drinks f						
		conducted with the 100 Hall					
		1/17 at 2:30 PM, revealed					
		er and did not usually carry					
	a patient load and wa	ent was NPO. The Unit					
		1 had regularly worked with					
	-	uld have observed Resident					
		n her room and should have					
		had seen it. The Unit					
		to provide an explanation as					
	-	ad received the coffee cup.					
		ated there was a coffee urn					
	-	ation with coffee cups that					
	matched the coffee ci	•					
		The Unit Manager added					
		e up an in-service for the					
		g NPO residents. The Unit					
	• •	the facility staff believed the					
		en given to Resident #1 by a					
	visitor, but it had not b	<b>c</b>					
	An interview conducte	ed with NA #1, on 6/1/17 at					
		e was able to identify if a					
		d the resident's nurse would					
	communicate that a re	esident was nothing by					
		ssed she was aware if a					
	resident had a feeding	g tube the resident may be					
		he care guides had been					
	printed out for the NA	-					
	transition though and	was going to a paperless					
		inable to locate a care guide					
	-	#1 was not aware how					
	Resident #1 had rece	eived the coffee cup. NA #1					
		ility staff were aware that					
		D and this had been the first					
	time she had seen Re	esident #1 with something to					

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/05/2017 APPROVED ). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345419	B. WING			_		) 01/2017
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LEXINGT	ON HEALTH CARE CENT	ER			17 CORNELIA DRIVE LEXINGTON, NC 27292			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	drink. NA #1 further of the coffee cup when s room to answer the ca she returned to the ro aware that the resident then the coffee cup w In an interview condu 10:54 AM she stated was available through Record (EMR) on the demonstrated how sh Resident #1's Kardex Kardex revealed Resi under the intervention detailed Resident #1 feeding tube. NA #1 Resident #1's Kardex Resident #1's Kardex Resident #1 was noth An interview conducte Nursing (DON) on 6/1 her expectation would knowledgeable about assignment. As well nursing staff should b should not receive for question about if a re- or liquids, the NA cou or consult the nurse. an active investigation	clarified she had not seen she had first entered the all light on 5/31/17. When om with NA #2 she became in thad the coffee cup and as removed. cted with NA #1 on 6/1/17 at resident nutrition information in the Electronic Medical Kardex. NA #1 e was able to access . A review of Resident #1's dent #1 had information in for Eating/Nutrition that was NPO and was on a acknowledged that the provided information that ing by mouth. ed with the Director of /17 at 11:56 AM revealed d be for a NA to be	F	323				

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