PRINTED: 04/05/2018 FORM APPROVED OMB NO. 0938-0391

| AND DLAN OF CORRECTION IN INDESTRUCTION NI IMBER | | | COMPLETED | | |
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| | 345235 | B. WING | | 02/2 | 23/2018 |
| ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| KES COMMUNITY | | | | | |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION DATE |
| CFR(s): 483.12(b)(1). §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibit neglect, and exploitat misappropriation of ref §483.12(b)(2) Establit to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on policy and physician and staff in implement their abust the areas of reporting investigation for 1 of (Resident #36) who horigin to the bridge of inner canthus and a residuent was a simple properties. | y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures that: t training as required at training as required at record review, family, terviews, the facility failed to be policies and procedures in the protection and the sampled residents and a bruise of unknown the nose, inner canthus to | F 60 | The resident affected: An internal investigation regarding resident numbors 36 was completed by the social worke February 27, 2018 and reviewed by the administrator. Resident, charge nurse Assistant Director of Nursing and direct caregivers were all interviewed regard potential resident abuse. The Resident | er r on e ct ing ts | 3/23/18 |
| Neglect, Mistreatmen Resident Property" da part: It is the policy of Twin encourage and suppo families, visitors, volu representatives in rep abuse, neglect, explo | t and Misappropriation of ated 11/10/2017, read in Lakes Community to ort all residents, staff, inteers and resident porting any suspected acts of itation, involuntary seclusion | | education on the facilities abuse polici and procedures regarding reporting, protection and investigation to all the individuals included in this investigation February 27, 2018. The abuse policies were reviewed by administrative staff (Administrator, Social Worker, Directon Nursing and Administrative Nurses). The training was completed in the quality Measure meeting on Tuesday February 27, 2018. The Human Resource Office meeting with the Administrative team of | n on s r of This ry er is | |
| | ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Develop/Implement A CFR(s): 483.12(b)(1) §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibin neglect, and exploitat misappropriation of refine suppropriation for suppropriation for 1 of refine suppropriation for 1 of refine suppropriation suppropriation suppropriation of suppropriation suppropriation or suppropri | ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) \$483.12(b) The facility must develop and implement written policies and procedures that: \$483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, \$483.12(b)(2) Establish policies and procedures to investigate any such allegations, and \$483.12(b)(3) Include training as required at paragraph \$483.95, This REQUIREMENT is not met as evidenced by: Based on policy and record review, family, physician and staff interviews, the facility failed to implement their abuse policies and procedures in the areas of reporting, protection and investigation for 1 of 1 sampled residents (Resident #36) who had a bruise of unknown origin to the bridge of the nose, inner canthus to inner canthus and a reddened area under the right eye. Findings include: A review of the facility policy titled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" dated 11/10/2017, read in part: It is the policy of Twin Lakes Community to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion or misappropriation of resident property. | ROVIDER OR SUPPLIER (ES COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) \$483.12(b) The facility must develop and implement written policies and procedures that: \$483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, \$483.12(b)(2) Establish policies and procedures to investigate any such allegations, and \$483.12(b)(3) Include training as required at paragraph \$483.95, This REQUIREMENT is not met as evidenced by: Based on policy and record review, family, physician and staff interviews, the facility failed to implement their abuse policies and procedures in the areas of reporting, protection and investigation for 1 of 1 sampled residents (Resident #36) who had a bruise of unknown origin to the bridge of the nose, inner canthus to inner canthus and a reddened area under the right eye. Findings include: A review of the facility policy titled "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property" dated 11/10/2017, read in part: It is the policy of Twin Lakes Community to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, exploitation, involuntary seclusion | ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (READ GENERAL PROVIDER (SACH MUNITY) SUMMARY STATEMENT OF DEFICIENCIES (READ GENERAL PROVIDER (SACH MUNITY) SUMMARY STATEMENT OF DEFICIENCIES (READ GENERAL PROVIDER STAN OF CORRECTION SHOULD GENERAL PARK OF CORRECTION SHOULD GENERAL PROVIDER STAN OF CORRECTION STAN OF CORRECTION SHOULD GENERAL PROVIDER STAN OF CORRECTION STAN OF | ROWIDER OR SUPPLIER RES COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of resident property, \$483.12(b)(2) Establish policies and procedures to investigate any such allegations, and \$483.12(b)(2) Establish policies and procedures to investigate any such allegations, and investigation for 1 of 1 sampled residents and investigation for 1 of 1 sampled residents in the areas of reporting, protection and investigation for 1 of 1 sampled residents (Resident S) who had ab trules of unknown origin to the bridge of the nose, inner canthus to inner canthus and a reddened area under the right eye. Findings include: A review of the facility policy titled "Abuse, Neglect, Mistreatment and Misappropriation of tesident property" dated 11/10/2017, read in part: It is the policy of Twin Lakes Community to encourage and support all residents, staff, families, wistors, volunteers and resident representatives in reporting any suspected acts of abuse, neglect, expolitation, involuntary seclusion or misappropriation of resident property. |

Electronically Signed

03/18/2018

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.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (2) MULTIPLE CONSTRUCTION . BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 345235 | B. WING _ | | | 02/ | /23/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| T14//51 1 4 1/ | 750 00MM INUTY | | | 3 | 801 WADE COBLE DRIVE | | | |
| I WIN LAK | ES COMMUNITY | | | В | BURLINGTON, NC 27215 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | (X5) COMPLETION DATE | | |
| F 607 | F 607 Continued From page 1 | | | | | | | |
| | facility that "abuse" a Federal and State La | | | | for a second time and audit for understanding. Also, copies of all the facility abuse policies were placed at enursing station for employee review or | | | |
| | "abuse" or suspicion | es must always report any of "abuse" immediately to | | | February 27. | | | |
| | | ne Administrator will involve | | | Residents potentially affected: An audi | | | |
| | | nnel as necessary to assist | | | all residents was completed during the | | | |
| | | gation and follow up. The ort to the Medical Director. | | | week of March 5, 2017. This included a | 3 | | |
| | Auministrator will rep | ort to the Medical Director. | | | head to toe skin check by a licensed nurse of all residents to identify bruisin | a or | | |
| | Investigation of injurie | es of Unknown Origin or | | | potential abuse. No other areas of | y oi | | |
| | | njuries of unknown origin or | | | concern were identified during this aud | lit | | |
| | suspicious injuries m | | | | These audits were reviewed by the Qu | | | |
| | | ut abuse: Injuries include, | | | Assurance Nurse for any area of conce | | | |
| | _ | bruising of the inner thigh, | | | The abuse/investigation policies were | | | |
| | | st, bruises of an unusual | | | reviewed by administrative staff | | | |
| | size, multiple unexpla | | | | (Administrator, Social Worker, Director | of | | |
| | | ot typically vulnerable to | | | Nursing and Administrative Nurses). T | | | |
| | trauma. | j. , | | | training was completed in the quality | | | |
| | | | | | Measure meeting on Tuesday Februar | у | | |
| | Resident #36 was ad | mitted on 12/10/17. | | | 27, 2018. The Human Resource Office | r is | | |
| | Resident #36 has a d | lagnosis that included | | | meeting with the Administrative team of | 'n | | |
| | Non-Alzheimer's dem | entia, anemia, and seizure | | | March 27, 2018 to review abuse policie | es | | |
| | disorder. | | | | for a second time and audit for | | | |
| | | | | | understanding. | | | |
| | | sion Minimum Data Set | | | A Training Blitz is scheduled for April | 3, 4 | | |
| | ` <i>'</i> | 7 revealed that Resident #36 | | | and 5 for all staff (Nursing, dietary, | | | |
| | · · · | tance for bed mobility, | | | Environmental Services, Activities). Th | | | |
| | extensive assistance | | | | training will include an abuse/investiga | | | |
| | | g and total dependence with | | | policy and procedure review. The facili | ty | | |
| | | 6 utilizes a wheelchair for | | | has fully developed policies and | | | |
| | | no impairment indicated to | | | procedures that address preventing | | | |
| | | emities. Resident #36 has a | | | abuse, neglect, and exploitation of | 14 | | |
| | | and long term memory | | | residents and misappropriation of residents | | | |
| | problems. The MDS | | | | property. These procedures also addre | SS | | |
| | | derate cognitive impairment | | | and define guidelines for protection, | | | |
| | | aking, and requires cues and | | | reporting and investigating. We will ret | rain | | |
| | supervision. | | | | all staff on these abuse policies and | | | |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCT G | | | TE SURVEY MPLETED |
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| | | 345235 | B. WING _ | | | | 02/23/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRE | ESS, CITY, STATE, ZIP CODE | | |
| TWANT LAW | VEC COMMUNITY | | | 3801 WADE C | OBLE DRIVE | | |
| I WIN LAP | (ES COMMUNITY | | | BURLINGTO | N, NC 27215 | | |
| (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 CORRECT EACH CORRECTIVE ACTION SHOU OSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| F 607 | problem/ onset of the and is at risk for about hematomas. The gowill be free from about The interventions in medications as orded to MD immediately a bruising/ bleeding/ serview of care plan problem/ onset of the falls related to historimpaired mobility and goal indicates that the interventions increach, complete falls participation in PT and Review of February | dated 12/13/17 revealed a e resident receiving aspirin formal bleeding, bruising and pal indicates that the resident formal bleeding/ bruising. Cluded administer fored, report accidents/ injuries and monitor for increased welling. dated 12/13/17 revealed a e resident being at risk for ry of falls, unsteady gait, d impaired cognition. The fine resident will be free of falls. Cluded keep call light within is risk assessment, encourage | F | reporting educate regarding injuries of injuries. Suspicion investigatraining with Worker. Systemic An adminursing rincidents the adminurain audit she complete impleme Director audit/mo order to order | g requirements. We will als staff on the requirements greporting and investigation of Unknown Origin or Susp Injuries of unknown origin us injuries must be immediated to rule out abuse. This will be led by the facility Social changes: inistrative nurse will review notes daily to ensure all post have been reported. Each inistrative nurse will complete to document the task weed. This daily audit was ented on March 19, 2018 The of Nursing or Designee will positive these sheets each Frensure compliance. This warted on March 23, 2018. | on of icious or iately s ocial all essible ete an eas he ll iciday in | |
| | that Resident #36 w bruise to bridge of n Resident #36 respon Will continue to mon An observation mad 12:53 PM revealed a noted to bridge of no canthus and a redde of Resident #36. An interview was co PM with nurse #1. To bruise to Resident # | note dated 2/15/18 revealed as noted to have a green ose of unknown origin. Insible party and MD notified. Initior and inquire as reason. Be by surveyor on 02/19/18 at a 1 x 1.5 inch bruised area ose, inner canthus to inner ened area under the right eye Inducted on 02/21/18 at 2:59 The nurse revealed that the 36 was of unknown origin. | | head to to the residents of the nurse of potential coordinal Nursing is policies in regarding quality monitoring monitoring monitoring the nurse of | the Week of March 5th, 20 toe skin audit is completed s on a weekly basis. This is to toe skin check by a licential residents to identify bruil abuse. The skin checks atte with the resident's bath staff are expected to follow regarding abuse reporting any area of concern note neasure Nurse is responsible to the audits weekly and not for compliance. | of all ncluded sed uising or days. | |

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| 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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| | | 345235 | B. WING _ | | | 02 | /23/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| TWIN LAP | ES COMMUNITY | | | | 01 WADE COBLE DRIVE JRLINGTON, NC 27215 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 607 | An incident report wa indicated that she did Nursing (DON) or the to Resident #36. A telephone interview at 10:35 AM with fam nurse verbalized that once the facility figure Family indicated that made. Family indicated what the result of the concluded. An interview was con AM with the DON. The was notified about brough 102/21/2019. She experies along with far notification. The DOI note should have been incident report. The expectation of staff wounknown origin was the Administrator. The Shave also been notific investigation. No investigation. No investigation. No investigation of the State Agency. If abuse, then the facility channels of reporting | (MD) aware of the bruise. It is completed. Nurse #1 If not notify the Director of a Administrator of the bruise of was conducted on 02/22/18 willy. Family stated that the she would telephone her end out what happened. It is no return call has been ted they were still unaware of facility investigation of the DON revealed that she wise on resident on the process to be notified of any milly notification and md in revealed that a nursing ten completed, as well as, an DON reiterated that her when they have a bruise of the proport to the DON and the process of the proport to the propore to the proport to the proport to the proport to the proport to | F | 607 | informational reference card that can attach to the employee nametag. This reference card will contain a summary information regarding abuse policies a reporting guidelines. These reference cards will be distributed at the Training Blitz sessions on April 3, 4 and 5th. Monitoring and QA: The Director Nursing and the Administrator are the persons assigner responsibility for ensuring the accepted Plan of Corrections is implemented full Following each investigation the administrator will complete an assessment checklist to ensure compliance with the facility's policies a guidelines regarding abuse reporting a investigation. This investigation checkles was implemented on March 12, 2018. administrative nurse will review all nursunotes daily to ensure all possible incide have been reported. Each day the administrative nurse will complete an audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday order to ensure compliance. This wee audit started on March 23, 2018. The Social Worker is our facility abuse officer and has led the staff training portion of this POC. She is also responsible for providing staff with annotation in the policies. This plan are audit will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility will be reviewed during the facility and the facility and the facility and the facility and the facility will be reviewed during the facility and the facility and the facility and the facility and the facility a | d d d ly. nd ist An sing ents / in kly | |

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| | | 345235 | B. WING | | | 02/23/2018 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOUL | | (X5) COMPLETION DATE | |
| F 607 | Worker on 02/23/18 a responsible for complete working report for insignation had an injury or bruis further revealed that sofficer and became a unknown origin verbarevealed that she recincident report and consuspicious in nature. In the believe the residence of the warrant a 24 hour or was considered to be investigation, 24 hour completed. Reporting of Alleged CFR(s): 483.12(c)(1)(f) §483.12(c) In responsing the properties of the worker of the source and misapproare reported immediate hours after the allegate that cause the allegate serious bodily injury, the events that cause the administrator of the officials (including to adult protective service). | ducted with the Social at 10:09 AM. She was eting a 24 hour and 5 day tances in which a resident e of unknown origin. She she was the facility abuse ware of injuries or bruises of lly or by email. The SW eived and reviewed the oncluded if the injury was She indicated that she did into bruise (located on her spicious area and did not 5 day working report that suspicious in nature. No or 5 day working report was violations 4) See to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or ing injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to | F 60 | Quality Assurance Committee for minimum of two quarters (Octobe This corrective was fully implem March 23, 2018. Additional traini staff will be completed by April 5 Follow up training with the Admir staff is scheduled for March 27, 2 | er 2018). ented on ng with all th, 2018. nistrative | 3/23/18 | |

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| | | 345235 | B. WING | | 02/23/2018 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | |
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| F 609 | §483.12(c)(4) Report investigations to the adesignated represent accordance with Stat Survey Agency, withi incident, and if the all appropriate corrective. This REQUIREMENT by: Based on record rev physician and staff in submit a 24 hour and Survey Agency and for unknown origin for (Resident #36). Findings Included: Resident #36 was ad Resident #36 has a control of the admission of the admiss | the results of all administrator or his or her tative and to other officials in the law, including to the State on 5 working days of the leged violation is verified to action must be taken. This not met as evidenced siew, resident, family, therviews the facility failed to its 5 day report to the State ailed to investigate a bruise of 1 of 1 sampled Residents Initiated on 12/10/17. Itiagnosis that included mentia, anemia, and seizure is sion Minimum Data Set 7 revealed that Resident #36 thance for bed mobility, for transfers, total g and total dependence with its 6 utilizes a wheelchair for no impairment indicated to remities. Resident #36 has a and long term memory #36 has moderate cognitive of decision making, and | F 609 | The resident affected: An internal investigation regarding resident number 36 was completed by the social worker February 27, 2018 and reviewed by the administrator. Resident, charge nurses, Assistant Director of Nursing and director caregivers were all interviewed regard potential resident abuse. The Resident Physician and Family were notified. The Social Worker, abuse officer, provided education on the facilities abuse policies and procedures regarding reporting, protection and investigation to all the individuals included in this investigation February 27, 2018. The abuse policies were reviewed by administrative staff (Administrator, Social Worker, Directon Nursing and Administrative Nurses). The training was completed in the quality Measure meeting on Tuesday Februar 27, 2018. The Human Resource Officer meeting with the Administrative team of March 27, 2018 to review abuse policifor a second time and audit for understanding. Also, copies of all the facility abuse policies were placed at a nursing station for employee review or | r on e e ct ing ts ne l es r of This ry er is on es each |

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| | | 345235 | B. WING | | | 2/23/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | | |
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| F 609 | Continued From page 6 | | F 60 | 9 | | | |
| | Review of care plan | dated 12/13/17 revealed a | | February 27. | | | |
| | problem/ onset of the | e resident receiving aspirin | | | | | |
| | | onormal bleeding, bruising | | Residents potentially affected: Ar | | | |
| | | e goal indicates that the | | all residents was completed during | - | | |
| | | rom abnormal bleeding/ | | week of March 5, 2017. This inclu | | | |
| | | entions included administer | | head to toe skin check by a licens | | | |
| | | red, report accidents/ injuries | | nurse of all residents to identify b potential abuse. No other areas of | • | | |
| | bruising/ bleeding/ sv | nd monitor for increased | | concern were identified during thi | | | |
| | bruising/ bleeding/ sv | vening. | | These audits were reviewed by the | | | |
| | Review of care plan | dated 12/13/17 revealed a | | Assurance Nurse for any area of | • | | |
| | | e resident being at risk for | | The abuse/investigation policies | | | |
| | I - | of falls, unsteady gait, | | reviewed by administrative staff | | | |
| | - | l impaired cognition. The | | (Administrator, Social Worker, Di | rector of | | |
| | goal indicates that th | e resident will be free of falls. | | Nursing and Administrative Nurse | es). This | | |
| | | luded keep call light within | | training was completed in the qua | • | | |
| | | risk assessment, encourage | | Measure meeting on Tuesday Fe | - | | |
| | participation in PT ar | nd OT. | | 27, 2018. The Human Resource | | | |
| | | 2040 1 11 11 11 | | meeting with the Administrative to | | | |
| | | 2018 Incident Log stated on | | March 27, 2018 to review abuse | policies | | |
| | source unknown. | t #36 had a hematoma, | | for a second time and audit for understanding. | | | |
| | Source unknown. | | | A Training Blitz is scheduled for | April 3 4 | | |
| | Review of progress r | note dated 2/15/18 indicated | | and 5 for all staff (Nursing, dietar | • | | |
| | | as noted to have a green | | Environmental Services, Activities | - | | |
| | | ose of unknown origin. | | training will include an abuse/inve | • | | |
| | _ | sible party and MD were | | policy and procedure review. The | • | | |
| | notified. Will continu | e to monitor and inquire as | | has fully developed policies and | | | |
| | to reason. | | | procedures that address preventi | ng | | |
| | | | | abuse, neglect, and exploitation of | | | |
| | | 2/19/18 at 12:53 PM revealed | | residents and misappropriation of | | | |
| | | d area noted to bridge of | | property. These procedures also | | | |
| | | to inner canthus and a | | and define guidelines for protection | | | |
| | | the right eye of Resident | | reporting and investigating. We w | | | |
| | #36. | | | all staff on these abuse policies a | | | |
| | Δn interview was con | nducted on 02/21/18 at 2:59 | | reporting requirements. We will a educate staff on the requirements | | | |
| | | he nurse revealed that the | | regarding reporting and investiga | | | |
| | | 36 was of unknown origin. | | injuries of Unknown Origin or Sus | | | |

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| | | 345235 | B. WING _ | | | 02 | /23/2018 |
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| TWIN I AL | ES COMMUNITY | | | 38 | 801 WADE COBLE DRIVE | | |
| I WIN LAN | ALS COMMONT | | | В | URLINGTON, NC 27215 | | |
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| F 609 | the Medical Director (An incident report wa was unaware of how verbalized that Resid combative and resisti indicated that she did Nursing (DON) or the to Resident #36. Nur report bruising in the Administrator. She fu #36 has not had any Nurse #1 verbalized to no changes in conditi the bruise. An interview was con AM with NA #1. She had a bruise to the nu vacation. She returned prior to Valentine's Da Resident #36 can be NA #1 indicated that stalls. An interview was con AM with NA #2 revea of bruising to Resider assisting in the Lakey did not indicate what The NA questioned of area as to what happ She indicted that other #2 verbalized that she An interview was con AM with NA #3 revea bruise on Resident #36 can be was sisting in the Lakey did not indicate what the NA questioned of area as to what happ She indicted that other #37 reveals that was con AM with NA #3 reveals bruise on Resident #38 reveals bruise reveals reveals reveals reveals reveals | dent #36 family and made (MD) aware of the bruise. s completed. The nurse the bruising occurred. She ent #36 does become ve to care. Nurse #1 I not notify the Director of Administrator of the bruise se #1 indicated that she will future to the DON and urther revealed that Resident falls to her knowledge. that Resident #36 has had on or regular routine; just ducted on 02/22/18 at 7:43 reported that Resident #36 urse when she returned from ed to work Monday the week ay. The NA verbalized that combative/ resistive to care. she was unaware of any ducted on 02/22/18 at 8:35 led that she was not aware in #36 until she was wood common area. The NA day she observed bruising. ther staff in the common ened to Resident #36 face. er staff were not aware. NA e did no further reporting. ducted on 02/22/18 at 8:58 led she first noticed the 36 face on last week. She | F | 609 | injuries. Injuries of unknown origin or suspicious injuries must be immediatel investigated to rule out abuse. This training will be led by the facility Social Worker. Systemic changes: An administrative nurse will review all nursing notes daily to ensure all possibincidents have been reported. Each dathe administrative nurse will complete audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday order to ensure compliance. This wee audit started on March 23, 2018. Starting the Week of March 5th, 2018, head to toe skin audit is completed of a residents on a weekly basis. This incluance head to toe skin check by a licensed nurse of all residents to identify bruisin potential abuse. The skin checks coordinate with the resident's bath day Nursing staff are expected to follow factoricies regarding abuse reporting regarding any area of concern noted. In quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Each employee will be issued an informational reference card that can attach to the employee nametag. This reference card will contain a summary | ole ay an / in kly a all ded g or s. cillity The or | |
| TAG | Continued From page She telephoned Resithe Medical Director (An incident report wawas unaware of how verbalized that Resid combative and resisti indicated that she did Nursing (DON) or the to Resident #36. Nur report bruising in the Administrator. She fu #36 has not had any Nurse #1 verbalized to no changes in condition the bruise. An interview was con AM with NA #1. She had a bruise to the nuvacation. She returned prior to Valentine's Da Resident #36 can be NA #1 indicated that shalls. An interview was con AM with NA #2 revea of bruising to Resider assisting in the Lakewell did not indicate what The NA questioned of area as to what happ She indicted that other #2 verbalized that she An interview was con AM with NA #3 revea bruise on Resident #36 can be NA #1 reveal to the was she was she was she was she was she was as to what happ She indicted that other #4 verbalized that she was con AM with NA #3 reveal bruise on Resident #36 can be not received that she was she | dent #36 family and made (MD) aware of the bruise. s completed. The nurse the bruising occurred. She ent #36 does become ve to care. Nurse #1 Inot notify the Director of Administrator of the bruise rese #1 indicated that she will future to the DON and urther revealed that Resident falls to her knowledge. That Resident #36 has had on or regular routine; just ducted on 02/22/18 at 7:43 reported that Resident #36 urse when she returned from ad to work Monday the week ay. The NA verbalized that combative/ resistive to care. She was unaware of any ducted on 02/22/18 at 8:35 led that she was not aware in #36 until she was wood common area. The NA day she observed bruising. The restaff in the common ened to Resident #36 face. For staff were not aware. NA de did no further reporting. | TAG | | injuries. Injuries of unknown origin or suspicious injuries must be immediatel investigated to rule out abuse. This training will be led by the facility Social Worker. Systemic changes: An administrative nurse will review all nursing notes daily to ensure all possib incidents have been reported. Each dathe administrative nurse will complete audit sheet to document the task was completed. This daily audit was implemented on March 19, 2018 The Director of Nursing or Designee will audit/monitor these sheets each Friday order to ensure compliance. This wee audit started on March 23, 2018. Starting the Week of March 5th, 2018, head to toe skin audit is completed of a residents on a weekly basis. This inclu a head to toe skin audit is completed of a residents on a weekly basis. This inclu a head to toe skin check by a licensed nurse of all residents to identify bruisin potential abuse. The skin checks coordinate with the resident's bath day Nursing staff are expected to follow factorics regarding abuse reporting regarding any area of concern noted. In quality measure Nurse is responsible for reviewing the audits weekly and monitoring for compliance. Each employee will be issued an informational reference card that can attach to the employee nametag. This | ole ay an vin kly a all ded g or s. Sillity | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345235 | B. WING | | | 02/23/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | STREET ADDRESS, CITY, STATE, ZIP CODI | | 02/20/2010 | |
| | | | | 3801 WADE COBLE DRIVE | | | |
| TWIN LAK | ES COMMUNITY | | | BURLINGTON, NC 27215 | | | |
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| F 609 | Continued From page | e 8 | F 60 | 9 | | | |
| | | uise. She did not recall what 1) stated. NA #3 did not | | reporting guidelines. These re cards will be distributed at the Blitz sessions on April 3, 4 and | Training | | |
| | revealed that he was bruising to the face of stated that the staff vibruise Resident #36 liglasses. The MD furfrom staff did not indianything suspicious anotification in his MD stated that he did not regards to the bruise resident wore glasses the time of the incider A follow up interview 9:14 AM revealed that Resident #36 wearing | Book. The MD further look at Resident #36 in The MD did not know if the s and did not assess her at | | Monitoring and QA: The Director Nursing and the Administrator are the persons responsibility for ensuring the Plan of Corrections is impleme Following each investigation t administrator will complete an assessment checklist to ensure compliance with the facility's p guidelines regarding abuse re investigation. This investigation was implemented on March 1 administrative nurse will revien notes daily to ensure all possi have been reported. Each da administrative nurse will comp audit sheet to document the ta completed. This daily audit was implemented on March 19, 20 | accepted ented fully. he re collicies and porting and on checklist 2, 2018. An w all nursing ble incidents y the collete an cask was as | | |
| | A follow up interview with NA #1 on 02/22/18 at 9:24 revealed that Resident #36 does not wear glasses. NA #1 was not aware of Resident #36 having glasses. She verbalized that if Resident #36 had glasses she would not keep them on. | | | Director of Nursing or Designe audit/monitor these sheets ea order to ensure compliance. audit started on March 23, 20 The Social Worker is our facili | ee will ch Friday in This weekly 18. | | |
| | AM with NA #4. She week she noticed bru while NA #2 was assi meal. The nurse aide the primary aide (NA primary aide (NA #1) NA #4 further reveale | ducted on 02/22/18 at 9:26 stated that on Monday this lise to Resident #36 face sting Resident #36 with her e indicated that she asked #1) about the bruise and the was not aware of bruise. ed that she reported bruise to Nurse #1). She verbalized | | officer and has led the staff tra portion of this POC. She is als responsible for providing staff training on abuse policies. Thi audit will be reviewed during t Quality Assurance Committee minimum of two quarters (Oct This corrective was fully imple March 23, 2018. Additional tra | aining so with annual is plan and he facility's for a ober 2018). emented on | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN | | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345235 | B. WING | | 02 | 2/23/2018 | | |
| | ROVIDER OR SUPPLIER | • | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | | | |
| (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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | CTION SHOULD BE O THE APPROPRIATE | | | |
| F 609 | falls. NA #4 did star become combative. Resident #36 will gr bite staff. She indic easy to redirect with offering Resident #3 revealed that she w wearing glasses. A telephone intervie at 10:35 AM with far notified via text mes regarding bruise on the nurse verbalized once the facility figure Family indicated that made. Family did not cause of the bruise. Family was not awa Resident #36 having of Resident #36 having of Resident #36 we indicated that Resid glasses at her last for buying them. An interview was conducted that the DON. Was notified about to 02/21/2019. She expressed along with far notification. The DO note should have be incident report. The expectation of staff unknown origin was | are of the resident having any te that Resident #36 can NA #4 verbalized that ab at staff and will attempt to ated that Resident #36 was a calm conversation and 36 a stuffed animal. NA #4 as not aware of Resident #36 www. was conducted on 02/22/18 mily revealed that family was asage from a private sitter 2/17/2018. Family stated that at that she would telephone her red out what happened. It no return call has been ot give any rationale as to re or has been informed of g falls. Family also not aware aring glasses. Family ent had a history of losing accility, so the family quit anducted on 02/22/18 at 11:17 The DON revealed that she or resident on the process to be notified of any amily notification and md DN revealed that a nursing sen completed, as well as, an a DON reiterated that her when they have a bruise of to report to the DON and Social Worker (SW) would | F 609 | staff will be completed by April 5t Follow up training with the Admir staff is scheduled for March 27, 2 | nistrative | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | (X: | 3) DATE SURVEY COMPLETED |
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| | | 345235 | B. WING _ | | | 02/23/2018 |
| | ROVIDER OR SUPPLIER | • | , | STREET ADDRESS, CITY, STATE, ZIP 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN C ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 609 | An interview with the 02:21 PM revealed the bruise of unknown of the Social Worker (Souspicions of abuse, through proper chand and 5 day report). Note that the 02/22/18 at 02:33 PM aware of bruise the 2003 PM aware of bruise did not warrant report in the location of bruise did physical abuse. A follow up interview Social Worker on 02 was responsible for day working report for resident had an injuriorigin. She further refacility abuse officer. Injuries or bruises of by email. The SW reand reviewed the incomplete that she did not belief (located on her nose) | restigation, 24 hour or 5 day completed. Administrator on 02/22/18 at hat her expectation of a rigin needs to be reported to EW). If there are any then the facility will go nels of reporting (24 hour to 24 hour or 5 day working | F6 | 609 | | |

| OLITICITY | OT OIL MEDIO, TILE OF | · · · · · · · · · · · · · · · · · · · | _ | | | | 7. 0000 0001 |
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| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 345235 | B. WING | | | 02/ | 23/2018 |
| | ROVIDER OR SUPPLIER | | | 38 | TREET ADDRESS, CITY, STATE, ZIP CODE 801 WADE COBLE DRIVE URLINGTON, NC 27215 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 609 | re-reviewed the CMS not meet the requirent bruise with Nurse #1 report. She further dit Assistant Director of It that she assumed the received the bruise for rail. She indicated no nursing staff to determine wearing glasses at the could have been the gobservation of a pair bedside table. She discould have been the gobservation of a pair bedside table. She discould have been the gobservation of a pair bedside table. She discould have been the gobservation of a pair bedside table. She discould have been the gobservation of a pair bedside table. She discould have been the gobservation of a pair bedside table. She discould have been the gobservation of a pair bedside table to the resident was cognitive be able to communicate had not spoken with sprovided or when the bruising. The SW veralso had behaviors at She stated there was behaviors of aggressis. Review of medical recassessment for date of the state of the communication of the state of the | The SW stated that she guidelines and stated it did nents. She discussed the that wrote the incident iscussed the injury with the Nursing. The SW verbalized is resident might have om her glasses, or the side of discussions were held with mine if the resident was e time. The SW assumed it glasses due to making an of glasses on the resident's id not validate if the glasses ent or another resident with ealed that she did not know ent was completed. She sion had been drawn or ent what was assumed as a uise. She further stated the ely impaired and would not atte what occurred. The SW staff in regards to care y initially observed any rbalized that the resident not care plan in place for the ion. | F | 609 | | | |
| F 610 SS=D | behaviors of aggressi | ion. Correct Alleged Violation | F | 610 | | | 3/23/18 |

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| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | 02/23/2010 | |
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| F 610 | Continued From page | | F 61 | 0 | | | |
| | | se to allegations of abuse, or mistreatment, the facility | | | | | |
| | §483.12(c)(2) Have e violations are thoroug | vidence that all alleged hly investigated. | | | | | |
| | . , , , | t further potential abuse, or mistreatment while the gress. | | | | | |
| | §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State | | | | | | |
| | Survey Agency, within incident, and if the all appropriate corrective | n 5 working days of the eged violation is verified action must be taken. | | | | | |
| | by: Based on record rev physician and staff in | terviews the facility failed to | | The resident affected: An inte investigation regarding resider | nt number | | |
| | canthus to inner cant under the right eye fo | area to bridge of nose, inner nus and a reddened area r 1 of 1 sampled Residents bruise of unknown origin. | | 36 was completed by the soci- February 27, 2018 and review administrator. Resident, charg Assistant Director of Nursing a | ved by the ge nurse, | | |
| | Findings Include: | | | caregivers were all interviewer potential resident abuse. The Physician and Family were no | Residents | | |
| | | mitted on 12/10/17. iagnosis that included entia, anemia, and seizure | | Social Worker, abuse officer, peducation on the facilities abuand procedures regarding repprotection and investigation to individuals included in this investigation. | provided se policies orting, o all the | | |
| | (MDS) dated 12/22/1 requires limited assis extensive assistance | ion Minimum Data Set 7 revealed that Resident #36 tance for bed mobility, for transfers, total g and total dependence with | | February 27, 2018. The abuse were reviewed by administrati (Administrator, Social Worker, Nursing and Administrative Nutraining was completed in the | e policies ive staff , Director of urses). This | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO. A. BUILDING | | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | 3801 WADE COBLE DRIVE | | |
| TWIN LAK | ES COMMUNITY | | | BURLINGTON, NC 27215 | | |
| (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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 610 | Continued From page | ge 13 | F 6 | 10 | | |
| F 610 | toileting. Resident # ambulation and has upper and lower ext BIMS of 0 with shor problems. Resident impairment with poor requires cues and so Review of care plan problem/ onset of the and is at risk for about hematomas. The gwill be free from about The interventions in medications as order to MD immediately about bruising/ bleeding/ so Review of care plan problem/ onset of the falls related to historimpaired mobility are goal indicates that to The interventions in reach, complete fall participation in PT and Review of progress that Resident #36 we bruise to bridge of the Resident #36 responotified. Will continuous reason. | a36 utilizes a wheelchair for no impairment indicated to remities. Resident #36 has a t and long term memory t #36 has moderate cognitive or decision making, and upervision. dated 12/13/17 revealed a le resident receiving aspirin normal bleeding, bruising and loal indicates that the resident normal bleeding/ bruising. cluded administer lered, report accidents/ injuries and monitor for increased swelling. dated 12/13/17 revealed a le resident being at risk for rry of falls, unsteady gait, and impaired cognition. The line resident will be free of falls. cluded keep call light within is risk assessment, encourage | F 6' | Measure meeting on Tuesda 27, 2018. The Human Resormeeting with the Administra March 27, 2018 to review all for a second time and audit understanding. Also, copies facility abuse policies were nursing station for employed February 27. Residents potentially affected all residents was completed week of March 5, 2017. This head to toe skin check by a nurse of all residents to ider potential abuse. No other an concern were identified durit These audits were reviewed Assurance Nurse for any and The abuse/investigation pol reviewed by administrative (Administrator, Social Work Nursing and Administrative training was completed in the Measure meeting on Tuesda 27, 2018. The Human Resormeeting with the Administra March 27, 2018 to review all for a second time and audit understanding. A Training Blitz is schedule and 5 for all staff (Nursing, of Environmental Services, Actraining will include an abus policy and procedure review has fully developed policies | purce Officer is tive team on buse policies for s of all the placed at each e review on ed: An audit of a during the s included a licensed ntify bruising or reas of ng this audit. If by the Quality ea of concern. Icies were staff er, Director of Nurses). This he quality ay February purce Officer is tive team on buse policies for ed for April 3, 4 dietary, tivities). This e/investigation of the facility and | |
| | The source, location incident was unknown | n and activity at the time of the wn. No equipment was d in the incident. Immediate | | procedures that address pre abuse, neglect, and exploita residents and misappropriat | eventing ation of | |

| 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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| NAME OF PI | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CO | | | |
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| F 610 | Continued From pagaction taken by staff completed of reside notification made. Fincident report dated Worker revealed that bruise of unknown on an accurate hist the injury was not or due to the location a injuries are noted at resident is on aspirin Nursing also reports in an uncontrolled methat the resident docreading. She also squarter upper bed rainjury. An observation madactic 12:53 PM revealed anoted to bridge of not canthus and a redder of Resident #36. An interview was con PM with nurse #1. She telephoned Resident #36. | ge 14 If was an assessment Int, family and physician Follow up notes on the d 2/15/2018 by the Social at she was made aware of the origin and that resident was orian. She further noted that consistent with physical abuse and that no other bruising or this time. She states that an and is a high falls risk. Is that resident flails her arms manner. The SW indicated les wear glasses at times for stated that the resident has ails that could account for the by surveyor on 02/19/18 at a 1 x 1.5 inch bruised area lose, inner canthus to inner lened area under the right eye anducted on 02/21/18 at 2:59 The nurse revealed that the did was of unknown origin. In the sident #36 family and made | F 6 | property. These procedures and define guidelines for procedures and define guidelines for procedures and these abuse policing reporting and investigating. All staff on these abuse policing reporting requirements. We educate staff on the requirer regarding reporting and investigating reporting and investigated to rule out abust training will be led by the fact Worker. Systemic changes: An administrative nurse will nursing notes daily to ensurincidents have been reported the administrative nurse will audit sheet to document the completed. This daily audit wimplemented on March 19, 2 Director of Nursing or Designa audit/monitor these sheets expressed in the process order to ensure compliance. audit started on March 23, 2 | also address of tection, We will retrain cies and will also ments estigation of or Suspicious origin or immediately se. This cility Social review all e all possible d. Each day complete an etask was was 2018 The nee will each Friday in This weekly 2018. | | |
| | An incident report w was unaware of how verbalized that Resi combative and resis indicated that she di Nursing (DON) or th to Resident #36. Sh report bruising in the Administrator. She | r (MD) aware of the bruise. ras completed. The nurse of the bruising occurred. She dent #36 does become stive to care. Nurse #1 id not notify the Director of the Administrator of the bruise the indicated that she will the future to the DON and further revealed that Resident of falls to her knowledge. | | Starting the Week of March head to toe skin audit is con residents on a weekly basis a head to toe skin check by nurse of all residents to ider potential abuse. The skin ch coordinate with the resident Nursing staff are expected to policies regarding abuse repregarding any area of conce quality measure Nurse is resident. | npleted of all . This included a licensed ntify bruising or necks 's bath days. o follow facility porting ern noted. The | | |

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| F 610 | Continued From page | e 15 | F 6 | 10 | | |
| | | hat Resident #36 has had on or regular routine; just | | reviewing the audits weekly monitoring for compliance. | | |
| | AM with NA #1. She had a bruise to the no vacation. She returne prior to Valentine's Do Resident #36 can be | ducted on 02/22/18 at 7:43 reported that Resident #36 urse when she returned from the downk Monday the week ay. The NA verbalized that combative/ resistive to care. She was unaware of any | | Each employee will be issu informational reference care attach to the employee nan reference card will contain information regarding abust reporting guidelines. These cards will be distributed at the Blitz sessions on April 3, 4 | d that can netag. This a summary of e policies and reference the Training | |
| | revealed that he was bruising to the face o not know if the reside assess her at the time A follow up interview 9:14 AM revealed tha Resident #36 wearing | MD on 02/22/18 at 9:07 AM verbally notified regarding f Resident #36. The MD did ent wore glasses and did not e of the incident. with Nurse #1 on 02/22/18 at at the she was not aware of g glasses. The resident was time of the incident as to | | Monitoring and QA: The Director Nursing and the Administrator are the person responsibility for ensuring the Plan of Corrections is implead Following each investigation administrator will complete assessment checklist to encompliance with the facility guidelines regarding abuse investigation. This investigation was implemented on March | ns assigned the accepted emented fully. In the an sure s policies and reporting and ation checklist | |
| | 9:24 revealed that Reglasses. NA #1 was having glasses. She #36 had glasses she An interview was con AM with NA #4. She secome combative. Resident #36 will grabite staff. She indicate easy to redirect with coffering Resident #36 | with NA #1 on 02/22/18 at esident #36 does not wear not aware of Resident #36 verbalized that if Resident would not keep them on. ducted on 02/22/18 at 9:26 stated that Resident #36 can NA #4 verbalized that b at staff and will attempt to ted that Resident #36 was calm conversation and a stuffed animal. NA #4 is not aware of Resident #36 | | administrative nurse will revolute administrative nurse will revolute administrative nurse will consume the completed. This daily audit implemented on March 19, Director of Nursing or Designaudit/monitor these sheets order to ensure compliance audit started on March 23, and The Social Worker is our factories. | view all nursing ssible incidents day the mplete an e task was was 2018 The gnee will each Friday in e. This weekly 2018. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345235 | B. WING | | 02 | /23/2018 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | · | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 610 | at 10:35 AM with fame the nurse verbalized once the facility figure family indicated that made. The family discause of the bruise. has been informed of Family also not aware glasses. Family indicated that made interview was concerned to a second the family quit buying the second that the family also been second that the family also been notification. The family also been notification investigation. No investigation. No investigation. No investigation was a second that the second that the second that the family also been notification. The second that the seco | w was conducted on 02/22/18 nily. The family stated that that she would telephone her ed out what happened. The no return call has been d not give any rationale as to The family was not aware or f Resident #36 having falls. re of Resident #36 wearing cated that Resident had a ses at her last facility, so the rem. Inducted on 02/22/18 at 11:17 The DON revealed that she ruise on resident on rects to be notified of any mily notification and md N revealed that a nursing en completed, as well as, an DON reiterated that her when they have a bruise of to report to the DON and social Worker (SW) would ed to assist in the restigation, 24 hour or 5 day completed. Administrator on 02/22/18 at nat her expectation of a rigin needs to be reported to W). If there are any then the facility will go nels of reporting (24 hour o 24 hour or 5 day working Administrator. No | F 610 | portion of this POC. She is also responsible for providing staff w training on abuse policies. This audit will be reviewed during the Quality Assurance Committee f minimum of two quarters (Octol This corrective was fully impler March 23, 2018. Additional train staff will be completed by April Follow up training with the Adm staff is scheduled for March 27. | vith annual plan and e facility's or a ber 2018). mented on hing with all 5th, 2018. inistrative | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONS | TRUCTION | (X3) DATE | SURVEY PLETED |
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| | | 345235 | B. WING _ | | | 02 | /23/2018 |
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| F 610 | | Social Worker (SW) on | F | 510 | | | |
| | aware of bruise the a SW reviewed the inci notes at the bottom of facility made the deted in ot warrant report unknown origin. SW regarding abuse and unknown origin to rev | I revealed that she became fternoon of 2/15/18. The dent report and completed f the incident report. The emination that the incident ting of being a bruise of pulled up CMS Memo reporting bruising of view. SW indicated that not meet definition of | | | | | |
| | Social Worker on 02/was responsible for or day working report for resident had an injury origin. She further refacility abuse officer. injuries or bruises of by email. The SW reand reviewed the incit the injury was suspicit that she did not belied (located on her nose) area and did not warr working report that we suspicious in nature. re-reviewed the CMS not meet the requirer bruise with Nurse #1 report. She further did Assistant Director of that she assumed the received the bruise for rail. She indicated not resident to the state of the state o | The SW stated that she guidelines and stated it did nents. She discussed the that wrote the incident iscussed the injury with the Nursing. The SW verbalized | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 345235 | B. WING | | 02/23/2018 |
| | ROVIDER OR SUPPLIER | | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 801 WADE COBLE DRIVE BURLINGTON, NC 27215 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCE | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| F 610 | could have been the observation of a pair bedside table. She obelonged to the residual staff. She further revif a side rail assessmented that no concluinterventions to previouse/result of the bresident was cognitive be able to communic had not spoken with provided or when the bruising. The SW veralso had behaviors a She stated there was behaviors of aggress. | ne time. The SW assumed it glasses due to making an of glasses on the resident's did not validate if the glasses dent or another resident with vealed that she did not knownent was completed. She usion had been drawn or ent what was assumed as a ruise. She further stated the vely impaired and would not eate what occurred. The SW staff in regards to care exp initially observed any erbalized that the resident and could have hit herself. It is no care plan in place for the sion. | F 610 | | |
| | behaviors of aggress Accuracy of Assessing CFR(s): 483.20(g) §483.20(g) Accuracy The assessment muresident's status. This REQUIREMEN by: Based on staff interfacility failed to accurate Data Set (MDS) asseconditions for pressurand failed to accurate | nents | F 641 | The resident affected: An MDS modification was completed on resider #12 on March 13, 2018 in order to accurately code the MDS assessment the area of skin conditions for Pressurulcers. A MDS modification was | in |

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| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
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| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| F 641 | 11/07/17 with a diag dementia, orthostati artery and chronic k A review of the most 02/14/18, coded as assessed Resident pressure ulcer and a pressure ulcers. The Resident #12 requiremobility and was confused for resident a Stage 2 pressure a Stage 2 pressure of the faciling Record for resident a Stage 2 pressure of the Resident pressure ulcer on least of the faciling Record for resident a Stage 2 pressure of the faciling Record for resident a Stage 2 pressure of the faciling Record for resident a Stage 2 pressure of Resident O2/11/18 documents of the faciling Record for resident a Stage 2 pressure of Resident O2/11/18 documents of the faciling Record for resident a Stage 2 pressure of Resident O2/11/18 documents of the faciling Record for resident and the faciling Record for resident of the faciling Record for resident and the faciling Record for resident and the facility of the faciling Record for resident and the facility of | dmitted to the facility on noses that included chypotension, coronary idney disease. It recent (MDS) dated a quarterly assessment, #12 at risk for developing as having no unhealed ne MDS further revealed ed extensive assistance with gnitively impaired. Ities Wound/Skin Healing #12 dated 01/30/18 revealed ulcer on left buttock. It # 12's nurses note on ed a two centimeter Stage two fit buttock. | F 64 | completed for resident #36 on Marc 2018 in order to accurately code the assessment in the area of accuratel coded behavior symptoms. Both car plans have been updated to reflect accurate assessments. Residents potentially affected: Duri weekly quality measures meeting or February 27, 2018, the IDT reviewe pressure ulcer report and made sur MDS and careplans were updated to accurately reflect pressure ulcers. Valso audited all residents receiving anti-anxiety and anti-psychotic medications to ensure the MDS and Careplanes accurately addressed behaviors. The plan of correction for deficiency includes retraining for the Interdisciplinary care plan team on N coding, CAA process, care planning RAI overview. The MDS Coordinated attended state approved training on February 22, 2018. She will be responsible for training the IDT. This training was completed on March 20 | e MDS y re ng or d the b v r this mMDS and r |
| | revealed she completor Resident #12. system failed to pull pressure ulcer durin order was missed at coded correctly. An interview with the was completed on 0 | pm. During this interview she leted the quarterly assessment. The MDS nurse stated the the new order for the g the look back period, so the assessment was not let Director of Nursing (DON) 2/22/18 at 2:09 pm. During leted she expected the MDS y. | | Nursing staff were reeducated on probehavior/skin condition changes documentation and reporting to the Interdisciplinary care plan team. We also created an internal user group to make communication easy. This was provided to all nursing staff via message board on March 5th, 2018 Training Blitz is scheduled for April 3 and 5 for all staff which will include the education on communication expect and reporting of behaviors and skin condition changes. | e have email notice our . A 3, 4 |

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| | MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345235 | B. WING _ | | 0: | 2/23/2018 |
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| TWIN LAK | ES COMMUNITY | | | BURLINGTON, NC 27215 | | |
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| | | | | | | |
| F 641 | Continued From pa | ge 20 | F 6 | 41 | | |
| | Resident #36 has a | as admitted on 12/10/17. diagnosis that included ementia, anemia, and seizure | | Systematic Changes: An adminurse will review all nursing rensure all new skin issues are have been appropriately reported day the administrative nurse an audit sheet to document the completed. This daily audit wimplemented on March 19, 20 Director of Nursing or Design audit/monitor these sheets earorder to ensure compliance. audit started on March 23, 20 | notes daily to nd behaviors orted. Each will complete he task was vas 018 The nee will ach Friday in This weekly | |
| | (MDS) dated 12/22, has a BIMS of 0 with problems. Resident impairment with porrequires cues and some behavioral symptoms. Review of the Treat dated December 20 behavioral symptoms 12/22/18 on the first symptoms were concepted. | ssion Minimum Data Set /17 revealed that Resident #36 /th short and long term memory t #36 has moderate cognitive or decision making, and supervision. Resident #36 had stoms coded. ment Administration Record of revealed that resident had his exhibited 12/16/18 through t and second shift. The ded on the Treatment ord as anxiousness, grabbing, staff, hitting, kicking, tation without harm to self or | | Starting the Week of March & head to toe skin audit is com residents on a weekly basis. a head to toe skin check by a nurse of all residents to ident change in skin condition. The coordinate with the resident's The quality measure Nurse is for reviewing the audits week monitoring for compliance. Monitoring and QA: In order to our plan of correction for efficing Tuesday we will have a quality meeting that consist of the form Administrator, Director of Nursing nurses, Quality Assurance Nurses, Quality Assurance Nurses, Quality Assurance Nurses. | pleted of all This included a licensed tify any e skin checks s bath days. s responsible dy and to monitor ciency, each ty measures sillowing staff: rsing, and , MDS urse, Social | |
| | 02/23/18 at 10:09 A completes Section Data Set (MDS). T was aware that Res stated that she did the assessment per | e Social Worker (SW) on M revealed that she E- Behaviors of the Minimum he SW verbalized that she sident #36 has behaviors. She not code any behaviors during riod because there were no poport the coding of behaviors. | | Worker, and Dietitian. This till will be utilized to review all far behaviors, weight loss, psych medication use, and falls. The for an IDT discussion on appellans, assessments and interpretains the Market permits the Mark | acility wounds, notropic is will allow ropriate care rventions. exchange of MDS nurse | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | ROVIDER OR SUPPLIER | | | 38 | TREET ADDRESS, CITY, STATE, ZIP CODE 801 WADE COBLE DRIVE URLINGTON, NC 27215 | • | |
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| F 641 | interviews or other do medical record when of the MDS. An interview with the 10:40 AM revealed th staff review all inform MDS. Develop/Implement C | that she did not use staff | | 6341 | needed to accurately code the MDS assessment and update care plans in a areas. These meetings began on February 27, 2018. The facility will monitor its performance make sure the solutions outlined above are sustained, and the corrective action evaluated for effectiveness by the Dire of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quart (October 2018). This corrective action be fully implemented by March 23, 201 | e to e n is ctor ers will | 3/23/18 |
| SS=D | implement a compreh care plan for each res resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identifiassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized s | cility must develop and tensive person-centered sident, consistent with the that §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive aprehensive care plan must 1/2 are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse | | | | | |

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| | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF PROVIDER OR SUPPLIER | | | STF | REET ADDRESS, CITY, STATE, ZIP CODE | 02/ | 23/2010 |
| TWIN LAKES COMMUNITY | | | | 01 WADE COBLE DRIVE | | |
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| F 656 Continued From page 22 provide as a result of PASA recommendations. If a faci findings of the PASARR, it rationale in the resident's revealed that her care plar updated on 02/10/18 by the resident #71's revealed that her care plar in the resident #71's revealed that her care plar in the resident #71's revealed that her care plar in the plan as of 16.98% in 1 | lity disagrees with the must indicate its nedical record. resident and the)-r admission and lice and potential for must document ire to return to the land any referrals to /or other appropriate comprehensive care cordance with the laragraph (c) of this lot met as evidenced and staff interview the laragraph (c) of this lidents (Resident 71). If to the facility on last included moderate irritable bowel, sease and others. The last (MDS) dated dent had intact linced a significant month. | F | 556 | The Resident affected: The care plant resident #71 was updated to reflect we loss on February 22, 2018. Residents potentially affected: During of weekly Quality Measures meeting, the reviewed all residents with significant weight loss for February 2018. Carepla were audited and updated as appropria The plan of correction for this deficience includes retraining for the Interdisciplina care plan team on MDS coding, CAA process, care planning and RAI overvied The MDS Coordinator attended state approved training on February 22, 2018 She will be responsible for training the IDT. This training was completed on March 20, 2018. Systematic Changes: Dietitian will revieweights on an ongoing basis and discussions. | ight our IDT ns ate. y ary ew. 3. | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 656 | address the weight lo dietary assessments. An interview on 02/21 Registered Dietician (responsible for monitoresidents and entering on the MDS. The RD monitored all weights significant weight chat the February significant capture Resident The RD revealed she 02/10/18 as having sididn't initiate a care p Resident #71 fell thro An interview on 02/21 Coordinator #1 revea her own portion of the disciplines are resporshe further stated she for completion but did was inputted. MDS Conce a discipline com MDS, they would go i and write a care plan. An interview on 02/22 Medical Doctor (MD) weight loss that signiff The MD stated Resid from the hospital obtupumped full of fluids. | did not have a care plan to ss and did not have a care plan to ss and did not have any /18 at 11:24 am with the (RD) revealed she is oring weights on all g all nutritional information also revealed she once a month on a nge report. The RD stated int weight change report did #71's decreased weight. updated the MDS dated gnificant weight loss but lan. She further stated ugh the cracks. /18 at 2:49 pm with MDS led she is responsible for their own sections. The reviewed the entire MDS in the cases arily review what coordinator #1 also reported upleted their portion of the noto the care assessment. /18 at 8:44 am with the revealed he expected a ficant from Resident #71. The ent #71 came to the facility anded, not eating and the further revealed he was of the significant weight | F | 656 | weight changes in our weekly quality measures meeting. Each week we will have a quality measures meeting that consist of the following staff: Administrator, Director of Nursing, and Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Soci Worker, and Dietitian. This time togethe will be utilized to review all facility wour behaviors, weight loss, psychotropic medication use, and falls. This will allow for an IDT discussion on appropriate caplans, assessments and interventions. This meeting will allow for an exchange information that permits the MDS nurses the opportunity to capture information needed to accurately code the MDS assessment and update care plans in a areas. Monitoring and QA: In order to monitor our plan of correction for efficiency, the dietician will submit a weight change report to the MDS Coordinator and Director of Nursing on monthly basis. The facility will monitor its performance make sure the solutions outlined above are sustained, and the corrective action evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quarte (October 2018). This corrective action be fully implemented by March 23, 201 | er ands, where er ands er ands, where er ands er and er an | |

| 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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| F 656 | Director of Nursing (Dooth revealed it was to resident with signification care plan. The Admin expectation the MDS entire MDS and make created. | 3/18 at 10:35 am with the OON) and the Administrator heir expectation any nt weight loss should have a istrator stated it was her Coordinator review the e sure care plans were | F6 | 356 | | | |
| F 657 SS=D | be- (i) Developed within 7 the comprehensive as (ii) Prepared by an initial includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and their and their resident reput practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev | ensive Care Plans prehensive care plan must I days after completion of essessment. Perdisciplinary team, that pited to resician. I with responsibility for the I and nutrition services staff. Peticable, the participation of esident's representative(s). The included in a resident's participation of the resident resentative is determined the development of the staff or professionals in fined by the resident's needs the resident. The including both the | F 6 | 957 | | 3/23/18 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | | | 3801 WADE COBLE DRIVE | | |
| TWIN LAK | ES COMMUNITY | | | BURLINGTON, NC 27215 | | |
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| F 657 | Continued From page | e 25 | F 65 | 7 | | |
| | | is not met as evidenced | | | | |
| | This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to revise a comprehensive care plan for a resident who developed a facility acquired stage 2 pressure ulcer for 1 of 1 residents reviewed for pressure ulcers (Resident #12). The findings included: Resident #12 was admitted to the facility on 11/07/17 with diagnoses that included dementia, orthostatic hypotension, coronary artery disease and chronic kidney disease. A review of the most recent MDS dated 02/14/18, coded as a quarterly assessment, assessed Resident #12 at risk for developing pressure ulcer and as having no unhealed pressure ulcers. The MDS further revealed Resident #12 required extensive assistance with mobility and was cognitively impaired. A review of Resident #12's comprehensive care plan, most recently revised on 02/14/18, revealed no plan of care for Resident #12's documented stage 2 pressure ulcer. The care plan indicated the resident was at risk for skin breakdown due to impaired mobility, dementia and incontinence. The approaches included assist with mobility, transfers and complete skin assessment quarterly. A review of the facilities Wound/Skin Healing Record dated 01/30/18 revealed a stage 2 pressure ulcer on residents left buttock. A review of Hospice wound care treatment order dated 01/31/18, indicated a treatment of | | | Resident affected: The Care plan of updated for resident #12 on February 2018 in order to accurately reflect to change in area of skin conditions for Pressure ulcers. Residents potentially affected: Durweekly quality measures meeting of February 27, 2018, the IDT reviewer pressure ulcer report and made surfly and careplans were updated accurately reflect pressure ulcers. In plan of correction for this deficiency includes retraining for the Interdiscicare plan team on MDS coding, CA process, care planning and RAI over The MDS Coordinator attended state approved training on February 22, 25 She will be responsible for training IDT. This training was completed or | ary 22, the or ing our on ed the re to The r plinary A erview. te 2018. the | |
| | | | | March 20, 2018. Nursing staff were reeducated on p skin condition changes documental and reporting to the Interdisciplinar plan team. We have also created a internal user group email to make communication easy. This notice w provided to all nursing staff via our message board on March 5th, 2018. Training Blitz is scheduled for April and 5 for all staff which will include education on communication expediand reporting of skin condition char Systematic Changes: An administrative murse will review all nursing notes of ensure all new skin issues and beh have been appropriately reported. | ction by care an as | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | ` ′ | LE CONSTRUCTION | , , | (X3) DATE SURVEY COMPLETED | |
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| TWIN LAK | ES COMMUNITY | | | 3801 WADE COBLE DRIVE | | | |
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| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| F 657 | Continued From page | e 26 | F 65 | 7 | | | |
| | dermacloud topical colleft buttock stage 2 p | ream applied as needed to ressure ulcer. | | an audit sheet to document the tas completed. This daily audit was implemented on March 19, 2018 T | | | |
| | | es note dated 02/11/18 entimeter Stage two pressure | | Director of Nursing or Designee wi audit/monitor these sheets each Fr order to ensure compliance. This | iday in | | |
| | documented a two centimeter Stage two pressure ulcer on left buttock. Review of Physician Order dated 02/16/18 revealed a order to clean with normal saline, apply medi-honey ointment and cover with foam dressing daily. An interview was conducted with the MDS nurse on 02/21/18 at 3:00 pm. During this interview she stated she updated the care plan, but did not revise the care plan to include the development of Resident #12's Stage 2 pressure ulcer. An interview with the Director of Nursing (DON) was conducted on 02/22/18 at 2:09 pm. The DON stated she expected care plans to be updated for any new pressure ulcer. | | | audit started on March 23, 2018. Starting the Week of March 5th, 20 head to toe skin audit is completed residents on a weekly basis. This is a head to toe skin check by a licen nurse of all residents to identify any change in skin condition. The skin coordinate with the resident so bath The quality measure Nurse is resp for reviewing the audits weekly and monitoring for compliance. Monitoring and QA: In order to more our plan of correction for efficiency Tuesday we will have a quality measure that consist of the followin Administrator, Director of Nursing, Assistant Director of Nursing, MDS nurses, Quality Assurance Nurse, Worker, and Dietitian. This time tog will be utilized to review all facility we behaviors, weight loss, psychotrop | of all ocluded sed / checks of days. consible limitor of asures g staff: and social gether younds, | | |
| | | | | medication use, and falls. This will for an IDT discussion on appropria plans, assessments and intervention. This meeting will allow for an exchainformation that permits the MDS of the opportunity to capture information needed to accurately code the MD assessment and update care plans areas. These meeting began on F 27, 2018. The facility will monitor its performation in the second in the s | allow te care ons. ange of urse on S in all ebruary | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 345235 | B. WING | | | 02/23/2018 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | · | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 657 | Continued From pag | e 27 | F 65 | make sure the solutions outline are sustained, and the corrective evaluated for effectiveness by to find Nursing. This plan will be reduring the facility Squality Assocommittee for a minimum of twe (October 2018). This corrective be fully implemented by March In order to monitor our plan of offor efficiency, each week we winguality measures meeting that the following staff: Administrate of Nursing, Assistant Director of MDS nurses, Quality Assurance Social Worker, and Dietitian. The together will be utilized to review wounds, behaviors, weight loss psychotropic medication use, and This will allow for an IDT discuss appropriate care plans, assessing interventions. This meeting will an exchange of information that the MDS nurse the opportunity information needed to accurate MDS assessment and update of in all areas. In order to monitor our plan of offor efficiency, the Quality Assur will submit a weekly wound repquality measures meeting) to the Coordinator and Director of Nur MDS Coordinator will review cafor accuracy regarding skin chafor accuracy regarding skin chafo | ve action is the Director eviewed surance vo quarters action will 23, 2018. correction will 23, 2018. correction will aconsist of or, Director of Nursing, and falls. Sission on ments and allow for at permits to capture ely code the care plans correction rance nurse out (at each the MDS rsing. The are plans anges. ormance to ed above we action is | |

| 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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| | | 345235 | B. WING _ | | | 02/ | 23/2018 |
| | ROVIDER OR SUPPLIER | | | 38 | REET ADDRESS, CITY, STATE, ZIP CODE 01 WADE COBLE DRIVE JRLINGTON, NC 27215 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | Continued From page | e 28 | F | 657 | of Nursing. This plan will be reviewed during the facility s Quality Assurance Committee for a minimum of two quarte (October 2018). This corrective action be fully implemented by April 13, 2018. | ers will | |
| F 732 SS=C | Posted Nurse Staffing | | F 7 | 732 | | | 3/1/18 |
| | Systems of the following staffing Information. Systems of the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. | | | | | | |
| | specified in paragrap daily basis at the beg (ii) Data must be post (A) Clear and readab (B) In a prominent pla residents and visitors §483.35(g)(3) Public | best the nurse staffing data th (g)(1) of this section on a sinning of each shift. ted as follows: the format. the readily accessible to the access to posted nurse stilling must, upon oral or | | | | | |
| | residents and visitors §483.35(g)(3) Public staffing data. The fact written request, make | access to posted nurse cility must, upon oral or nurse staffing data for review at a cost not to | | | | | |

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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 345235 | B. WING | | 02/23/2018 | |
| | ROVIDER OR SUPPLIER | , | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE | , 32.20.20.10 | |
| | | | | BURLINGTON, NC 27215 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETION | |
| F 732 | Continued From pag | e 29 | F 73 | 2 | | |
| | posted daily nurse st 18 months, or as req is greater. This REQUIREMENT by: Based on observation facility failed to post of for the second and the in an area visible to re Findings included: On 02/19/18 at 10:45 of the building reveal second floor and the On 02/19/18 at 5:15 facility revealed no so floor and the third floo On 02/20/18 at 8:34 building revealed no floor and the third floo On 02/20/18 at 3:57 facility revealed no so floor and the third floo An interview on 02/20 Director of Nursing re daily staffing sheets a adjacent from the nu staffing sheets include | acility must maintain the affing data for a minimum of uired by State law, whichever I is not met as evidenced on and staff interviews, the the nurse staffing information aird floors out of three floors esidents and visitors. I AM an initial morning tour ed no staff posting on the third floor of the facility. PM an afternoon tour of the facility. AM a morning tour of the staff posting on the second for of the facility. PM an afternoon tour of the facility. PM an afternoon tour of the staff posting on the second for of the facility. PM an afternoon tour of the staff posting on the second for of the facility. PM an afternoon tour of the staff posting on the second for of the facility. PM an afternoon tour of the second for of the facility. D/18 at 4:13 PM with the evealed that the facility used and they are located rise's stations. The daily led a breakdown of nurses | | The staffing sheets were present and posted on the second and third floors during the survey period. These sheer reflected the facility name, current dat scheduled staff (RNs, LPNs and CNA and Resident Census. What was not reflected on the sheet was the total number and the actual hours worked those staff members identified on the staffing sheet. The staffing sheet was updated to include all the required information on February 21, 2018. The updated staffing sheets are posted date ach household by the Third Shift Nur The Lakewood Neighborhood Nurse Supervisor is tasked with adjusting posting to reflect schedule changes. At the end of each 24 hour period the share provided to the Director of Nursing order to monitor for compliance and accuracy. The facility will monitor its performance make sure the solutions outlined above are sustained, and the corrective active evaluated for effectiveness by the Director of Nursing. This plan will be reviewed during the facility's Quality Assurance Committee for a minimum of two quantities. | ets e, s), by ese illy in rse. At eets g in e to //e on is ector l tters | |
| | per shift. The Directo | scheduled by name per unit or of Nursing further rate sheet was not used to | | (October 2018). This corrective action was fully implemented. | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | , , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | 1, , | (X3) DATE SURVEY COMPLETED | |
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| | | 345235 | B. WING _ | B. WING | | 02/23/2018 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI: TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE | |
| F 758 SS=D | walked to the nurse's that was posted. The reflective of total nurse per shift. The Director she was responsible nurse staffing and the completed and posted. An interview on 02/20 Administrator reveale were updated and da of the current sheet by Administrator's expect sheets are updated to and posted daily. Free from Unnec Psyc CFR(s): 483.45(c)(3) (sheets brain activities processes and behave but are not limited to, categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehere sident, the facility manuelss the medication | cours per shift. In an stor of Nursing and surveyor station to review the sheet edaily staffing sheet was not sing hours on a daily basis or of Nursing verbalized that for completing the daily einformation had not been d. 20/18 at 04:34 PM with the ed that daily staffing sheets ily nursing hours were left off leing used. The cotation was daily staffing to include daily nursing hours echotropic Meds/PRN Use (e)(1)-(5) 20/20 Drugs. 20/20 hotropic drug is any drug that is associated with mental evior. These drugs include, drugs in the following | | 758 | | 3/23/18 | |

PRINTED: 04/05/2018 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | 1 02/20/2010 | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION | |
| F 758 | drugs receive gradus behavioral intervent contraindicated, in a drugs; §483.45(e)(3) Residus psychotropic drugs unless that medicated diagnosed specific in the clinical record §483.45(e)(4) PRN are limited to 14 dates §483.45(e)(5), if the prescribing practition appropriate for the beyond 14 days, he rationale in the residual in th | dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented | F 75 | | | |
| | time limited in durat (Resident #11) reviewed ications. The finding included | tion for 1 of 1 residents ewed for unnecessary | | PRN Xanax. The physician determine that the resident needs to continue the medication for a timeframe of six months. New order was clarified by Assistant Director of Nursing. Physician was reeducated via phone by the | ned use of k the | |

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| 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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| NAME OF P | ROVIDER OR SUPPLIER | 1 | <u>'</u> | STREET ADDRESS, CITY, STATE, ZIP (| CODE | 1 02/20/2010 | |
| | /=0.001414111TV | | | 3801 WADE COBLE DRIVE | | | |
| I WIN LAK | ES COMMUNITY | | | BURLINGTON, NC 27215 | | | |
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| F 758 | Disorder, unspecified Unspecified Dementi disturbance, Major depisode, unspecified Alzheimer's Disease prostate without lower The annual minimum 08/23/2017 (Admissi was moderately impassed behaviors or rejection #11 received an antiadays during the MDS A review of Physician revealed Xanax 0.25 as needed (PRN) based date for this PRN Xa Physician's progress "needs prn Xanax in agitation." Review of Consultant dated, 2/7/2018, revealed Xanax 0.25 as needed (PRN) based to this PRN Xa Physician's progress "needs prn Xanax in agitation." Review of Consultant dated, 2/7/2018, revealed (PRN) alprazolam for patient's status. (Hoston Marchael (Pontal Interview) was consulted the expectation of the Marchael (Pontal Interview) was weekly, I the word "indefinitely the attention of the Marchael (Pontal Interview) was weekly, I the word "indefinitely the attention of the Marchael (Pontal Interview) was weekly, I the word "indefinitely the attention of the Marchael (Pontal Interview) was weekly, I the word "indefinitely the attention of the Marchael (Pontal Interview) was consulted to the Marchael (Pontal Intervi | Inoses that included Anxiety Id., Parkinson's Disease, Id. a without behavioral Id., Systemic atrophy, Id., unspecified, Enlarged Id. are urinary tract symptoms. Id. data set (MDS) dated Id. on) indicated Resident #11 Id. aired. There were no Id. of care noted. Resident Id. anxiety medication on 2 of 7 Id. period. In sorders dated 02/06/2018 Img. 1/2 tab to be given on an Id. Id. are was not a stop Id. are w | F 7 | administrator and survey to February 22, 2018. Resident potentially affected all current orders was comensure compliance with the This was completed by Mark All administrative nursing a medical director were reed new regulation regarding Find psychotropic drugs by the on February 22, 2018. All reducated at the Training Bifor April 3, 4, and 5th, they expected to know these or limited to 14 days unless of indicated with a timeframe 6 months. Each nurse will monitor compliance when initiated. Systemic changes: All administrative nursing a medical director were reed new regulation regarding Find psychotropic drugs by the conference of the psychotropic drugs by the son February 22, 2018. All reducated at the Training Bifor April 3, 4, and 5th, they expected to know these or limited to 14 days unless of indicated with a timeframe 6 months. Each nurse will monitor compliance when initiated. All PRN psychotropic med entered with a 14 day stop another approved timefrance and the psychotropic med entered with a 14 day stop another approved timefrance. | ed: An audit upleted to is regulation. arch 15, 2018 staff and the ducated on the PRN orders for Administration arch 15 check will be ders need to otherwise no longer the ducated on the PRN orders for Administration archeological archeologi | an to are | |
| | Director (Facility MD | nducted with the Medical) on 2/22/2018 at 9:02 AM. Ire of the new regulation, with | | by the physician. Monitoring: The ADON, or run a weekly report of all n | - | | |

| | ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ' ' | (X3) DATE SURVEY COMPLETED | | |
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| (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 CORRECTIC X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 758 F 867 SS=D | out of the facility, it go I leave here today, all | ent Activities | F 7 | ensure compliance. This report will be reviewed at the weekly quality meass meeting. In addition, the pharmacy consultant will audit all PRN psychot orders during the monthly review to ensure compliance. The facility will monitor its performan make sure the solutions outlined about are sustained, and the corrective act evaluated for effectiveness by the Di of Nursing. This plan will be reviewed during the facility's Quality Assurance. Committee for a minimum of two qual (October 2018). This corrective action be fully implemented by March 23, 2 | ce to ve on is ector d rters n will | 3/23/18 |
| | §483.75(g)(2) The quassurance committee (ii) Develop and impleaction to correct ident This REQUIREMENT by: Based on record revifacility's Quality Asse. Committee failed to not procedures and monithe committee put in This was for two recit originally cited in Januare recritification survey recited in February 20 recertification survey, the areas of accuracy | emust: ement appropriate plans of tified quality deficiencies; is not met as evidenced few and staff interview the ssment and Assurance naintain implemented tor these interventions that to place in February 2017. ed deficiencies which were uary 2017 during a and was subsequently 018 on an annual The deficiencies were in | | F867 Resident affected: The Care plan wa updated for resident #12 on February 2018 in order to accurately reflect the change in area of skin conditions for Pressure ulcers. The care plan for resident #71 was updated to reflect vloss on February 22, 2018. An MDS modification was completed on resident #12 on March 13, 2018 in order to accurately code the MDS assessment. | v 22, e veight ent | |

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| | | | | 38 | 801 WADE COBLE DRIVE | | |
| TWIN LAK | (ES COMMUNITY | | | В | URLINGTON, NC 27215 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 867 | surveys of record shinability to sustain an Program. The finding included: This tag is cross reference. F641 MDS accuracy and record reviews to code the Minimum Din the area of skin concept (Resident #12) and for the behavior symptoms and sampled residents. During the recertificate facility was cited for MDS for Level II Prence Resident Review for (Resident #38). F656 Care Plan: Bas staff interview the facility was cited for the plan to address weight significant weight lost residents (Resident in During the recertificate facility was cited for comprehensive care an anticoagulant me | the facility during two federal ow a pattern of the facilities of effective Quality Assurance of effective Quality failed to accurately effective effective and effective | F | 867 | the area of skin conditions for Pressur ulcers. A MDS modification was completed for resident #36 on March 2018 in order to accurately code the Nassessment in the area of accurately coded behavior symptoms. Both care plans have been updated to reflect accurate assessments. Potential Residents affected: During our weekly quality measures meeting on February 27, 2018, the ID reviewed the pressure ulcer report and made sure MDS and care plans were updated to accurately reflect pressure ulcers. We also audited all residents receiving anti-anxiety and anti-psycho medications to ensure the MDS and C planes accurately addressed behavior The plan of correction for this deficien includes retraining for the Interdisciplir care plan team on MDS coding, CAA process, care planning and RAI overy The MDS Coordinator attended state approved training was completed on March 20, 2018. During our weekly Quality Measures meeting, the IDT reviewed all residents with significant weight loss for February 2018. Carepl were audited and updated as appropri The plan of correction for this deficien includes retraining for the Interdisciplir care plan team on MDS coding, CAA process, care planning and RAI overy The MDS Coordinator attended state | tic care es. cy harry iew. | |
| | An interview on 02/2 | 3/18 at 12:31 pm with the | | | approved training on February 22, 20° She will be responsible for training the | | |

| 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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| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 867 | Continued From pag plan of correction for after there were no is | two quarters but stopped | F 86 | March 20, 2018. Systematic Changes: An adm nurse will review all nursing nensure all new skin issues an have been appropriately reported day the administrative nurse of an audit sheet to document the completed. This daily audit was implemented on March 19, 20 Director of Nursing or Designaudit/monitor these sheets easorder to ensure compliance. audit started on March 23, 20 Starting the Week of March 5 head to toe skin audit is compresidents on a weekly basis. It a head to toe skin check by a nurse of all residents to identic change in skin condition. The coordinate with the resident's The quality measure Nurse is for reviewing the audits week monitoring for compliance. Dietitian will review weights of basis and discuss weight change week we will have a quality meeting that consist of the fol Administrator, Director of Nursing, nurses, Quality Assurance Nurses, Q | notes daily to and behaviors orted. Each will complete the task was as 018 The nee will ach Friday in This weekly 018. Sth, 2018, a pleted of all This included a licensed ify any e skin checks a bath days. It is responsible that allow and on a weekly anges in our eting. Each neasures llowing staff: rsing, and the together cility wounds, notropic is will allow | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED 02/23/2018 | | |
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| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | | (X5) COMPLETION DATE | | |
| F 867 | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | F 86 | plans, assessments and interval This meeting will allow for an a information that permits the M the opportunity to capture informeded to accurately code the assessment and update care areas. Monitoring and QA: In order to monitor our plan of for efficiency, each Tuesday war a quality measures meeting the the following staff: Administrate of Nursing, and Assistant Dire Nursing, MDS nurses, Quality Nurse, Social Worker, and Dietime together will be utilized to facility wounds, behaviors, we psychotropic medication use, This will allow for an IDT discus appropriate care plans, assessinterventions. This meeting with an exchange of information the MDS nurse the opportunity information needed to accurate MDS assessment and update in all areas. These meeting be February 27, 2018. The facility will monitor its performake sure the solutions outling are sustained, and the correct evaluated for effectiveness by of Nursing. Minutes from the wasure meeting will be reviewed plan will be reviewed during the reviewed plan will be reviewed during the reviewed plan will be reviewed during the reviewed dur | exchange of IDS nurse ormation e MDS plans in all formation we will have not consist of tor, Director ector of a Assurance etitian. This or review all eight loss, and falls. Lussion on sments and ill allow for not eat permits by to capture tely code the care plans egan on formance to ned above tive action is a the Director Quality ewed the training mprovement. In QA. This | | | |

| 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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| | | 345235 | B. WING | | 02/23/2018 | | | |
| | ROVIDER OR SUPPLIER | | ; | STREET ADDRESS, CITY, STATE, ZIP CODE 3801 WADE COBLE DRIVE BURLINGTON, NC 27215 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE | | |
| F 867 | Continued From page | , | F 867 | DEFICIENCY) | | | | |
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