	-	ID HUMAN SERVICES					FORM A	APPROVED
			()(0) 1411 77					0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		X3) DATE SU COMPLE	
		345283	B. WING				R-C	; 2/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	I	01/02	./2010
MOORES	/ILLE CENTER				ENWOOD DRIVE			
				MOOF	RESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS		{F 00	0}				
	Centers for Medicare acceptable allegation immediate jeopardy c							
	verification of the faci of the immediate jeop status of the ongoing facility provided evide was removed on 06/2 on 07/02/18 the facilit compliance for F 600 lower scope and seve harm with potential for that is not immediate continues the process implementation of the	, F 607, and F 835 at a erity (D) isolated, no actual or more then minimal harm jeopardy while the facility s of monitoring the eir corrective actions.						
{F 600} SS=D	CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or	{F 60	0}			7/	/2/18
								6) DATE
	cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATUR	<b>νμ</b>		TITLE			7/06/2018
							51	

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.

PRINTED: 07/13/2018

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 07/13/20 RM APPROVE IO. 0938-039
TATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DAT COM	E SURVEY IPLETED
		345283	B. WING			R-C 7/02/2018
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
				550 GLENWOOD DRIVE		
MOORES	VILLE CENTER			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
{F 600}	Continued From page	e 1	{F 600	)}		
	hospital Medical Doci interviews the facility from a significant inju 3 residents sampled was discovered to ha and chest and was se where it was discover wall hematoma (a col blood vessels), right I hematoma in which b ruptured capillaries u mild superior endplat T12 (thoracic spine). This deficiency was of immediate jeopardy of 06/20/18. The facility allegation on 06/26/1 06/28/18. A revisit wa and found the facility jeopardy effective 06 severity of this deficie (isolated with no actu more than minimal ha jeopardy). The text fm 06/20/18 had been bu removal of the immediant all staff members were	on the complaint survey of		<ul> <li>F 600 Free from Abuse and Net</li> <li>1. Facility failed to protect resid from a significant injury of unkn Resident #1 no longer resides a facility. Facility staff failed to sa care for resident #1, resulting i Investigation was not able to va substantiate abuse. Though the evidence of an improper transfer facility has concluded that the m cause of Resident #1 is injuries related to an improper transfer This conclusion is drawn from t of the hospital records and the Directors evaluation of injuries. conclusion was made 6/26/18.</li> <li>2. All resident have potential to effected. Unit Managers and R Nurse reviewed all incident reprinterviewed alert and oriented m determine if any subsequent inj unknown origin had occurred, m significant issues were identifie Non-interviewable Residents or #1 unit were assessed during investigation, to determine if an were present. No significant iss The above was initiated on 6/8/ completed on 6/14/18.</li> </ul>	ent # 1 own origin. at this fely provide n injuries. alidate or ere is no er, the nost likely s was technique. he review Medical This be tegional orts and esidents to juries of no d. n Resident uy injuries sues noted.	
	10/27/15 with diagnose without behavioral dis	n dmitted to the facility on ses that included: dementia sturbances, history of tach (mini stroke), and		" Charge nurses were educated Nurse Practice Educator related completion of Risk Managemer Electronic Incident Reports for injuries/bruises that are noted.	d to nt System all	

Facility ID: 923353

If continuation sheet Page 2 of 53

PRINTED: 07/13/2018

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		COMPLETED
					R-C
		345283	B. WING		07/02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MOORES	VILLE CENTER			550 GLENWOOD DRIVE MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE
{F 600}	Continued From page	e 2	{F 600	)}	
			<b>,</b>	education was initiated on 6/8/18 a	nd
		ecent quarterly Minimum		completed on 6/25/18.	
	. ,	d 05/16/18 revealed that		" On 6/08/18 Education on Safe Re	
		erely cognitively impaired		Transfers/Handling was initiated wi	
		ve assistance of 2 staff		nursing staff and completed 6/25/1	
	members with bed m	iew of the MDS revealed that		education was completed by Nurse Practice Educator and Unit Manage	
		no anticoagulants (blood		" Education was completed with all	
	thinners) during the a	<b>u</b>		staff related to abuse & neglect/ inju	
				unknown origin. Included in this edu	
	Review of a care plai	n revised on 05/22/18 read in		were the definitions of injuries (brui	
	part, Resident #1 req	uired limited to extensive		fractures, skin tears), and residents	s⊡ right
		es of daily living due to		to be free from these injuries. Durin	•
		tia. The goal of the care plan		education the staff were made awa	
		t #1's care needs would be		the facility had had a major injury o	
	anticipated and met t			unknown origin. This education wa initiated on 6/08/18 and completed	
		Inctioning. The interventions sto bilateral arms and		6/25/18. This education was completed	
		ensive assistance utilizing a		for all staff by the Nurse Practice E	
		erson assistance. May use		and Unit Manager.	
	sit to stand lift if need	-			
	Review of an Initial A	Ilegation Report dated		3. All future injuries will be investigation	ated
	05/25/18 at 6:30 PM	revealed that Resident #1		according to regulation to ensure re	esident
		own source that included a		safety and prompt investigations ar	e
		b area and right upper/inner		completed.	
	-	ated that injury had been		" PCC Clinical Dashboard (which sl	nows
		law enforcement agency on ed employees were listed as		all patients who have a change in condition note) will be reviewed in c	
	Nursing Assistant (N			morning meeting. Incident reports (	
		, , , , , , , , , , , , , , , , , , ,		are maintained electronically in the	
	Review of a 5-workin	g day report dated 06/01/18		Management System) will also be	
		t #1 had been investigated		reviewed in the Clinical Morning Me	eeting
		r purple bruising to right		by the Nursing Leadership team to	-
		medial side with purple		determine if there have been any n	ew
		al chest. The report indicated		injuries.	
		been reported to local law		" The Unit Managers and/or their	
		working day report included		designees will do random walking r three times a week to monitor resid	
	priet statements from	n NA #1, #2, and #3. The	1	Intree times a week to monitor resid	ent

Facility ID: 923353

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION	(X3) DATE	0.0938-03
	CORRECTION	IDENTIFICATION NUMBER:	. ,			LETED
			A. BUILDING			-C
		345283	B. WING			-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	077	02/2010
				550 GLENWOOD DRIVE		
MOORES	VILLE CENTER					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETIO DATE
{F 600}	Continued From pag	e 3	{F 600	)}		
. ,		art, "other residents on the	(	handling (care being provided, tr	ansfers	
	-	and none had issues with		being conducted properly) and to		
		sments completed on the unit		residents are free from abuse/se		
	with no further injurie			injuries. These rounds are under		
	assigned to Residen	t #1 on 05/25/18 were		direction of the Administrator, an	id any	
	interviewed and none	e of the staff were aware that		discrepancies will be reported to	him for	
	Resident #1 had brui	ising to right inner arm and		review. If the Administrator is no	t	
	-	nt #1 was a 1-2 person		available, the Interim/Replaceme		
	-	sfers. His skin was frail and		Director of Nursing will be respon-		
		rm protectors to decrease the		oversight. Interim DON started 6		
	-	incident was reported to the		"The Administrator and Regiona		
	-	dical Doctor (MD). There was		will also randomly review the PC		
		e in this case" No cause of		Dashboard and electronic incide		
	the bruise/injury was	identilied.		weekly to determine if there are injuries that require an investigat		
	An interview was cor	nducted with Resident #1's		so, ensure that an investigation i		
		6/06/18 at 9:48 AM. The		completed accordingly. This pro-		
	-	d that she had visited him on		be followed until the Quality Ass		
		0 PM and witnessed him		and Performance Improvement		
		. The family member stated		Committee determines otherwise	э.	
		ident #1 had no bruising and		" All investigations will be review	ed by the	
	was his usual self. S	he stated that on 05/25/18 at		Administrator and the Regional	Nurse to	
	approximately 6:30 F	PM she received a phone call		ensure that injuries are investiga	ited	
		g her that they had found		thoroughly to determine cause.		
	•	sident #1's right arm and		" The Interim/Replacement Direc		
		ly member stated she		Nursing or Regional Nurse will a	lso	
	-	er to the facility to see the		randomly audit (with a minimum		
	-	She added that when she		frequency of 5x/month) Safe Res		
		ch she described as dark ht arm extending over to his		Handling for care being provided transfers conducted to ensure re		
		ie and she also noted a large		are free from serious injuries. Th		
		nt #1's right chest area. She		education was started on 6/08/1		
		d the facility what had		concluded on 6/25/18.		
		replied, "we don't know what		" The Interim/Replacement Direct	ctor of	
		ily member stated she		Nursing and Administrator will ra		
		aw enforcement at around		question 10 staff members week	-	
		sponded to the facility and		determine their knowledge of the	-	
	-	happened to Resident #1.		definitions of resident injuries, ho		
		stated she directed the law		report them, and the residents ri		

Facility ID: 923353

If continuation sheet Page 4 of 53

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING		R-C
		345283	B. WING		07/02/2018
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	•
MOORES	VILLE CENTER			550 GLENWOOD DRIVE MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
{F 600}	Continued From page	e 4	{F 600]	}	
	enforcement question they replied, "we don	ns to the facility and again 't know what happened." The aled local law enforcement		free from these injuries. These begin on 6/26/18	audits will
             		cy Medical Services (EMS) transferred to the local		4. The results of these audits a monitoring will be reviewed mo The Quality Assurance and Per Improvement Committee, to en	nthly in formance
	on 06/05/18 revealed chest wall pectoralis the skin), ill-defined le	an obtained in the hospital I the following: right anterior hematoma (bleeding under eft upper lobe opacity may		compliance with the plan. Regi to review and/or attend QAPI M monthly.	leeting
	which blood has esca capillaries usually du	sion (a type of hematoma in aped from ruptured e to trauma), and mild mpression fracture of T12		The Administrator is responsible compliance with this plan of cor with oversight provided by the F Vice President of Operations an Regional Nurse.	rection, Regional
	enforcement Detectiv Detective who was as that on 05/25/18 one the call made from Re from the facility. He re was made aware from happened to her fam stated that when the the staff was unable to Resident #1 he called hospital. The Detective the ER and observed surprised by the apper and the extent of the briefly spoke to the E pictures but that was He added that he wo	aducted with the local law ye on 06/07/18 1:30 PM. The ssigned to the case stated of his officers responded to esident #1's family member esponded to the facility and in the family something had ily member. The Detective officer saw the bruises and to tell him what happen to d EMS to transport him to the ve stated he responded to I the bruises and was earance of the dark bruises bruises. He added that he R doctor and obtained some all that he had time to do. uld be going back over to the taff at some point but had		5. Alleged date of compliance J	luly 2, 2018

Facility ID: 923353

If continuation sheet Page 5 of 53

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 07/13/2018 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		345283	B. WING			R- 07/0	C 2/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE	0170	2/2010
			55	50 GLENWOOD DRIVE			
MOORES	VILLE CENTER		м	OORESVILLE, NC 2811	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE
{F 600}	dated 05/25/18 revea Resident #1 from 11:0 AM on 05/25/18. The revealed that NA#2 ca 05/25/18 from 7:00 Al for Resident #1 from care for Resident #1 from care for Resident #1 from care for Resident #1 for until he was sent to the for evaluation. An interview was cond 06/06/18 at 11:33 AM cared for Resident #1 to 7:00 AM on 05/25/7 cared for him and was She stated that night self and sometime in bathed Resident #1 a day. NA #4 stated that #1 on the morning on at all on his right arm that he had a small br but the nurse was alre #4 did not recall any p #1's right chest area to no bruising to his righ stated if she would has she would have repor no knowledge of how An interview was cond 06/06/18 at 11:26 AM cared for Resident #1 until 11:00 AM. She a time she had ever tak she clearly remember stating "it was crazy to	led that NA #4 cared for 00 PM on 05/24/18 to 7:00 assignment sheet also ared for Resident #1 on M to 11:00 AM, NA #3 cared 11:00 AM to 3:00 PM, NA #1 from 3:00 PM to 5:00 PM Resident #1 from 5:00 PM Resident #1 from 5:00 PM te Emergency Room (ER) ducted with NA #4 on . NA #4 confirmed that she from 11:00 PM on 05/24/18 18 and that she routinely s familiar with his needs. Resident #1 was his usual the morning hours she nd got him dressed for the t when she bathed Resident 05/25/18 he had no bruises or chest area. She added ruise to his left-hand area eady aware of that area. NA protrusion from Resident but confirmed that there was t arm or chest area. She twe seen any new bruising ted it to the nurse and had the bruises occurred.	{F 600}				

If continuation sheet Page 6 of 53

	-					FORM	): 07/13/2018 1 APPROVED
STATEMENT (	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE COMP	LETED
		345283	B. WING		_		-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
			5	50 GLENWOOD DRIVE			
MOORES	/ILLE CENTER			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	breakfast." NA #2 stat and asked her to help wheel-chair. NA #2 st had reported that Res assist with transfers a bathed and dressed a transferred to his chai entered Resident #1's made sure his brief w of his pants down and she pulled his pants u a gait belt and pivoted She stated that she d right arm or chest but bathed and dressed v and he had a shirt on his right arm so the an visible to her. She add movement to his chai transfer. NA #2 stated Resident #1 in his chai anymore care to him AM and NA #3 took o added she had no kno occurred. An interview was con 06/08/18 at 9:50 AM. worked with Resident assisting NA #2 on 05 the side of the bed an to his chair. NA #6 states assisted NA #2 with tr his chair she was mov and was not in Reside day. She added that to Resident #1's right	I had to get 4 people up for ted that she grabbed NA #6 o get Resident #1 up to his ated that in report NA #4 sident #1 required 2 person and that he had already been and just needed to be ir. NA #2 stated that she is room that morning and as dry by just sliding the top d he was dry so she stated up and her and NA #6 used d Resident #1 to his chair. id not see any bruising to his added he was already when she arrived for duty and his geri sleeve was on rm and chest were not ded it was one quick r and was very easy to d that after they placed air she did not render because she left at 11:00 ver her assignment. She owledge of how the bruises	{F 600}				

Facility ID: 923353

If continuation sheet Page 7 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES				RINTED: 07/13/2018 FORM APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION		ABNO. 0938-0391 B) DATE SURVEY COMPLETED
		345283	B. WING			R-C 07/02/2018
NAME OF PI	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, 2	ZIP CODE	01/02/2010
			550	) GLENWOOD DRIVE		
MOORES	/ILLE CENTER		мс	DORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
{F 600}	transfer. She added s how the bruises occur An interview was cond 06/06/18 at 11:45 AM came to work on 05/2 responsible for Reside he arrived at 11:00 AN up in his chair and wa for lunch. NA #3 state returned Resident #1 #7 began their last root lay them down for the after he and NA #7 ha resident and exited th #1's room to lay him of However, NA #3 state Resident #1's room th could see Resident #' chair was empty beside stated that he saw NA be NA #6 behind the of #1. He added that wh members in the room exited the room and a continue their round. Resident #1's room le never visualized his s of how the bruises occ An interview was cond 06/06/18 at 12:00 PM was working on the up resided on 05/25/18.3 she and NA #3 stated and had just exited ar NA #3 stated he was	e was just assisting with a he had no knowledge of rred. ducted with NA #3 on . NA #3 confirmed that he 5/18 at 11:00 AM and was ent #1. He stated that when M Resident #1 was already is taken to the dining room d that after lunch someone to his room and he and NA und to change everyone and afternoon. He added that ad laid down another e room he entered Resident down and change him. ed that when he entered he curtain was pulled and he 1's feet in the bed and his de the bed. NA #3 also A #2 and who he believed to curtain changing Resident en he saw the 2 other staff tending to Resident #1 he again met up with NA #7 to NA #3 stated that he was in less than 30 seconds and kin and had no knowledge curred. ducted with NA #7 on . NA #7 confirmed that she	{F 600}			

Facility ID: 923353

If continuation sheet Page 8 of 53

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	2: 07/13/2018 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345283	B. WING				-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
MOORES	VILLE CENTER			550 GLENWOOD DRIVE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	stated Resident #1 wastated she does not k #1 in the bed that after returned to her and st already in the bed the care to the other resid had no knowledge of An interview was come 06/08/18 at 11:13 AM 05/25/18 she had wor 7:00 AM to 3:00 PM at transferred to the unit She stated that when 3:00 PM there was no report and so she state people and get them stated that at approxin Resident #1's room to him and he was restir on and his brief was as provided incontinent of placed pants on him at the wheel-chair by he stated she did not not or chest area but state his brief and apply clo stated she had no kno bruises occurred. She her shift at 5:00 PM R wheelchair beside his An interview was come 06/06/18 at 3:50 PM. arrived for her shift or relieved NA #1. She at	room he returned and as already in the bed. NA #7 now who placed Resident rmoon and when NA #3 ated that Resident #1 was y continued with providing lents. She added that she how the bruises occurred. ducted with NA #1 on . NA #1 confirmed that on ked on a different unit from and at 3:00 PM she where Resident #1 resided. she arrived at the unit at o staff present to give her ted her round to change ready for supper. NA #1 mately 3:40 PM she went to o provide incontinent care to og in the bed, with no pants soaked. She stated she care to Resident #1 and and then transferred him to rself with no gait belt. NA #1 ice any bruises to his arms ed she only had to change ths to his lower half. She owledge of the how the e added that when she left tesident #1 was sitting in his bed waiting for supper.	{F 60	D}			

Facility ID: 923353

If continuation sheet Page 9 of 53

	MENT OF HEALTH AN					FOR	D: 07/13/2018 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE COM	E SURVEY PLETED
		345283	B. WING	i			R-C 7/ <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES	VILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΞIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
{F 600}	Resident #1 was his u of pain or discomfort. had on a short sleeve came up to his elbow stated that he ate 100 taken back to his roor 5:30-6:00 PM she beg for bed and noticed th arm and chest area. If had a large protrusion had light purple bruisi stated that she had ca evening of 05/24/18 a dressed him for bed th right arm or chest are was not there. She sta of what happened to b that when she discove immediately reported An interview was cond 06/06/18 at 3:22 PM. she worked with Resi stated that after support Resident #1 to his root and when she remove purple bruising to his and came and reported went to look at the bru them she went and go (NS) and the Director came to the room and Nurse #1 stated that st the geri sleeve from h lot of facial grimacing right arm was touched bruises were not pres- she had worked and st	Usual self and had no signs She added that Resident #1 e shirt and geri sleeve that with jogging pants. She 0% of the meal and he was m and at approximately gan to undress Resident #1 he dark purple bruise to his NA #5 stated that he also in to his right chest area that ing surrounding it. NA #5 ared for Resident #1 on the as well and when she here was no bruising to his ta and the large protrusion ated she had no knowledge Resident #1. NA #5 stated ered the bruises she it to Nurse #1. ducted with Nurse #1 on Nurse #1 confirmed that dent #1 on 05/25/18. She	{F (	600			

If continuation sheet Page 10 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345283	B. WING				R-C 1 <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		02/2010
					550 GLENWOOD DRIVE		
MOORES	VILLE CENTER				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	added that he had a k and she stated, "I tho in there." Nurse #1 st of how the bruises oc An interview was con 06/07/18 at 5:38 PM. 05/25/18 she reported AM and 11:00 AM and unit Resident #1 resid between 4:00 PM and break room having a were in there talking. #3 state, "man we dro asked them "did you f replied "no we used to further stated that she nurse and NA #3 state anything" we just pick in the bed. She stated outside of Resident # them talking about br NS that "maybe you s #1 and NS told NA #8 business." NA #8 stat her assignment and c about what she had h An interview was con 06/06/18 at 4:12 PM. 05/25/18 sometime at me and stated she ne look at Resident #1. T entered his room and right mid arm and a k there was bruising be his side. She added ti looked bluish and loo	anot on his right chest area ught something was broken ated she has no knowledge curred. ducted with NA #8 on NA #8 stated that on d for her shift between 10:30 d was working on the same ded. She added that d 5:00 PM she was in the snack and NA #3 and NA #1 NA #8 stated she heard NA opped Resident #1" and I not use the lift" and NA #3 op and bottom." NA #8 e asked them did you tell the ed "no we did not say ted him up and put him back d later there was commotion 1's room and she heard uises and she stated to the should talk to" NA #3 and NA 8 "to mind your own ed after that she returned to lid not say anything else	{F (	500}			

Facility ID: 923353

If continuation sheet Page 11 of 53

	-					FORM	: 07/13/2018 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _			(X3) DATE COMPI	
		345283	B. WING		_	R-	-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, ST		011	52/2010
10 112 01 11				50 GLENWOOD DRIVE			
MOORES	VILLE CENTER			MOORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	instructed to be very of were moving him. The #1's family was notifie facility and they called and they called EMS ER. She stated that b enforcement arrived a Doctor (MD) was notified STAT (now) orders was the local law enforcent the MD was again not going to the ER. The no idea how the bruiss Resident #1 did not m injuries to himself but possible that he was stated that NA #8 was what happened and the situation and I told he business and get bac reported to me that sh #1 talking about dropp An interview was conto 06/08/18 at 1:09 PM. 05/25/18 Nurse #1 ca Resident #1. She stat his room his shirt had witnessed dark purple arm and light bruising reported to me that the present the evening b advised Nurse #1 to of X-ray to rule out any f Resident #1 was. She the facility but had to because the family was	expression so the staff were careful with him when they e NS stated that Resident ed and they came to the d the local law enforcement to take Resident #1 to the efore the local law at the facility the Medical fied of the new bruising and ere given for x-rays. When ment decided to call EMS tified that Resident #1 was NS stated she honestly had es occurred and stated nove enough to cause those added "it was very well dropped." The NS also is asking questions about rying to get involved in the r she needed to mind her k to work but she never he had heard NA #3 and NA ping Resident #1. ducted with the DON on The DON stated that on illed me to come and look at ted that when she entered	{F 600}				

If continuation sheet Page 12 of 53

	MENT OF HEALTH AN						FORM	D: 07/13/2018 APPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·					SURVEY PLETED
		345283	B. WING					
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	CODE		
MOORES	VILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD B		(X5) COMPLETION DATE
{F 600}	bedside and EMS wa #1 to the local hospita Administrator that the Resident #1 was goin stated that she had no bruises occurred and to had any knowledge occurred. She added able to move enough believed something han not being forth coming An observation of Res local hospital on 06/07 #1 was resting in bed alert and incoherently extensive dark purple right upper chest area the bruising extended had turned to a yellow The right upper arm a bruising that extended around the upper arm his left side and dark to the right chest area have facial grimacing turning and reposition his pain level. An interview was cond Medical Doctor (HMD The HMD stated that Resident #1 to the ho took over his case on that when he first met he believed that movi	s preparing to take Resident al and she updated the family was upset and that ig to the hospital. The DON to knowledge of how the no one that she had spoken e of how the bruises that Resident #1 was not to harm himself and that appened but the staff was g. sident #1 was made in the 7/18 at 3:50 PM. Resident with eyes open, he was r verbal. There was bruising noted from the a down to his right hip area, a cross the abdomen but v color across the abdomen. also contained purple d approximately 3 inches b. Resident #1 was noted to purple bruising was visible riding to the back of Resident to have a large protrusion a. Resident #1 was noted to while being assisted with hed but was unable to voice	{F 6	600)				

If continuation sheet Page 13 of 53

TATEMENT C	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPL	
		345283	B. WING		R-(	C 2/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE		2/2010
				550 GLENWOOD DRIVE		
MOORES	ILLE CENTER			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
{F 600}	Continued From page	e 13	{F 600	}		
		used the bruising. The HMD				
		t after they performed a				
		aled a chest wall hematoma				
	•	outside the blood vessels) a type of hematoma in which				
	blood has escaped fr	om ruptured capillaries				
		a) he determined that				
	1 0	ing could not have caused he HMD stated it would take				
		to cause the lung contusion				
		his injuries it appeared that				
		e been dropped. He added				
		ntusions a lot in motor n the elderly who have fallen				
		ot cognitively aware to put				
		preak the fall. The HMD also				
	•	sion on Resident #1's right				
		to be a pectoral muscle tear would need to perform a				
		and Resident #1 was not				
	physically appropriate	e for that test. The HMD				
		ourple bruises indicated that				
	-	or acute and that when the rellow that indicates that they				
	-	al. He added that it would be				
		ries were life threatening due				
	•	and over-all health but				
	initially he would say	NO.				
	An interview was cor	ducted with the				
	Administrator on 06/0	08/18 at 11:36 AM. The				
		that he was notified on				
		nt #1 was discovered to his right arm and chest area				
		rived back at the facility				
	Resident #1 had bee	n transported to the ER. The				
		ed a copy of the police report notographs so his knowledge				

Facility ID: 923353

If continuation sheet Page 14 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345283	B. WING				-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES	VILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	He added that by the would assume that Re dropped or someone investigation did not of Resident #1 or how h facility. The Administrative facility knew what to come forward and had an open-door polencouraged the staff. The acting Administratimmediate jeopardy of The facility provided a compliance to remove which is described be June 26, 2018 Facility respectfully st of compliance for F-6 Abuse & Neglect/Failinjuries of Unknown Compliance for F-6 Abuse & Neglect/Failinjuries of Unknown Compliance for S-6 Abuse & Neglect/Failinjuries of Unknown Compliance for F-6 Abuse & Neglect/Failinjuries of Unknown Compliance for F-6 Abuse & Neglect/Failinjuries of Unknown Compliance for S-6 Abuse & Neglect/Failinjuries of Unknown Completed and all we on the Administrator completed and all we on Ad	reports of the bruises he esident #1 was either "man handled" him but our conclude what happened to e acquired the injuries in the ator stated that someone in happened and they needed report it, he added that he licy and he always to come to him. ator was notified of the on 06/20/18 at 10:22 AM. an acceptable allegation of e the jeopardy on 06/28/18 elow: ubmits the below allegation 00: ure to Protect and Prevent Origin. esident # 1 noted to have hest, right upper arm, and ng notified and came into the ident, spoke with several 2, and #3) on duty and of the physician. d x-rays of the ribs, right oulder which were re negative for fractures. mpleted and sent in the	{F 6	600}			

Facility ID: 923353

If continuation sheet Page 15 of 53

PRINTED: 07/13/2018

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	: 07/13/2018 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í				(3) DATE COMP	
		345283	B. WING				R-	
		040200		0	STREET ADDRESS, CITY, STATE, ZIP CODE		07/	02/2018
NAME OF P	ROVIDER OR SUPPLIER							
MOORES	VILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	Ē	(X5) COMPLETION DATE
{F 600}	have resident sent to enforcement was noti facility and filed a repo o Resident was set to discharge summary diagnosis included, A Altered Mental Status Failure and tachycard summary he also had right chest wall and a ER documentation sta appear to be in any di discharged home unti tachycardia". This info reviewed 6/26/18. " Resident # 1 has " May 28th-June 1 interviews of staff and alert and oriented res was conducted by the interviewed included 3 . Director of Nursing interviewed alert and " June 1, 2018 - In by the Director of Nur " Facility unable to injuries or name a per " June 7, 2018, sta nurse aid) was remov permanently due to per " June 8, 2018 o Administrator re- post survey, due to is investigation was han Nursing, in particular suspended, and the in thorough and delayed	the hospital. Local law fied and responded to the ort. In to the hospital. According y from hospital, his admitting spiration Pneumonia, , Chronic Respiratory ia. According to discharge diagnosis of Hematoma to Pectoralis Muscle Strain. ates that resident "did not istress, and was going to be I he had a run of ventricular ormation was obtained and not returned to the facility. st: Investigation included I agency staff, as well as idents. This investigation e Director of Nursing. Staff Staff Members # 1, #2 and # g stated that she had oriented residents. itial investigation concluded sing. determine the cause of rpetrator. off member # 8 (agency ed from schedule erformance issues.	{F 6	600}				

Facility ID: 923353

If continuation sheet Page 16 of 53

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDI		R-C
		345283	B. WING		07/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
				550 GLENWOOD DRIVE	
MOORES	VILLE CENTER			MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLETI E APPROPRIATE DATE
{F 600}	Continued From page	a 16	{F 6	300)	
(i 000)			{Γ U	500}	
		assigned to Resident # 1 on gency nurse aides: # 1, #2,			
		noved from the schedule on			
	6/08/18.				
	" June 14, 2018 - 3	Second investigation			
	concluded				
	-	le to substantiate abuse for			
	Resident # 1 o Not able to deter	mine any staff member			
	directly involved.	mine any stan member			
	-	cided to permanently remove			
		taff members (#1, #2, and			
	· ·	e due to inconsistencies in			
		reports of them being			
	untruthful from other				
		ncy was notified by the e 8, 2018 that the facility did			
		specific nurse aides to			
		nder any circumstances.			
		e ( #3) was placed back on			
	the schedule at the c	onclusion of the investigation			
		and had worked six shifts			
		18. Investigation showed			
		d not provided any care for			
		and corroborating statement ember validates this nurse			
	aids noninvolvement.				
	" Emergency Roor	m Physician Documentation			
	from 5/25/18 includes				
		ined and reviewed 6/26/18.			
		e ecchymosis over anterior			
		arm. No notable bruising back, which is contrary to the			
	initial report by the da				
	o Normal ROM (ra				
		physician to speak to police			
		ian states that he told the			
		my opinion that the patient			
	has a tear to his right	pectoralis muscle with			

If continuation sheet Page 17 of 53

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 07/13/2018 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY LETED
		345283	B. WING				-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, O	CITY, STATE, ZIP CODE		
				550 GLENWOOD DI	RIVE		
MOORES	/ILLE CENTER			MOORESVILLE, N	NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	could have occurred of wheel chair and is not abuse, neglect or gros o The patient contin o I have done my b daughter) that we do needs treatment in the nursing care, which sl nursing home, is appr know that even if patie likely be discharged th agreed that we may re home. " The Hospital Disc 6/17/18, when reside another SNF, states th o Resident not in a o He is stable for d o Discharge Diagno chest wall, improving. Pectoralis muscle strate was obtained and rev " Facility Medical D Physician documenta Discharge Summary f (had previously been statement in which he likely occurred during " June 20, 2018 - o Regional Nurse a (#3) from schedule per agency was notified, o staff member involved no documentation as returned him to sched available this date). " Administrator has	a. I do believe that this during transfers from bed to a necessarily an indication of as negligence" nues to rest peacefully best to explain to her (the not see any condition that e hospital and ongoing hould be provided in the opriate. I let the daughter ent were admitted, he would he next day, the daughter eturn him to the nursing charge summary from nt was discharged to he following: ny distress. ischarge to SNF bis: Hematoma of right Tachycardia resolved, and ain stable. This information iewed 6/26/18. Director, reviewed the ER tion as well as the for Resident # 1, on 6/26/18 on vacation) and provided a e indicates that the injury	{F 60	00}			

Facility ID: 923353

If continuation sheet Page 18 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 07/13/2018 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING					-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
				5	50 GLENWOOD DRIVE			
MOORES	/ILLE CENTER			Μ	IOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
{F 600}	<ul> <li>investigation, the Investigation, the Investigation, the Investigalia. Friday 6/15 and</li> <li>Facility staff failed resident # 1, resulting protect and prevent in Investigation was not substantiate abuse. To of an improper transfet that the most likely can injuries was related to technique. This conclusion of the hospital Directors evaluation of was made 6/26/18.</li> <li>Actions Taken: <ul> <li>The Administrato allegations of Abuse 8 unknown origin are prinvestigation was record on 6/08/18, and curre contact with Resident Administrator to verify of abuse.</li> <li>Unit Managers ar all incident reports an oriented residents to cinjuries of unknown or significant issues were Non-interviewable Rewere assessed during if any injuries were printed. The above was completed on 6/14/18</li> <li>Charge nurses was for all injuries/bruises</li> </ul> </li> </ul>	estigator has not returned Tuesday 6/26/18. d to safely provide care for in injuries. Facility failed to juries for resident #1. able to validate or Though there is no evidence er, the facility has concluded use of Resident #1's an improper transfer lusion is drawn from the records and the Medical of injuries. This conclusion r will ensure all future & Neglect/Injuries of comptly investigated. An opened by the Administrator int employees who had had # 1 were interviewed by the reporting of all allegations and Regional Nurse reviewed d interviewed alert and determine if any subsequent rigin had occurred, no e identified. sidents on Resident # 1 unit investigation, to determine essent. No significant issues as initiated on 6/8/18 and ere educated by the Nurse ated to completion of Risk Electronic Incident Reports	{F 6	00}				

If continuation sheet Page 19 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345283	B. WING				-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				55	50 GLENWOOD DRIVE		
MOORESVILLE CENTER				М	IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 600}	on 6/25/18. "On 6/08/18 Educ Transfers/Handling wastaff and completed 6 completed by Nurse F Managers. "Education was correlated to abuse & neorigin. Included in this definitions of injuries ( tears), and residents' injuries. During this earning made aware that the f injury of unknown originitiated on 6/08/18 arr This education was correlated to abuse Practice Education 3. Action Items: "All future injuries according to regulation and prompt investigat "PCC Clinical Dassing patients who have a correlated who have a correlated in clinical reports (which are marking Risk Management Sy in the Clinical Morning Leadership team to do any new injuries. "The Unit Manage will do random walking to monitor resident hast transfers being conduct the Administrator, and reported to him for resident to for resident to him for him for him for	ation on Safe Resident as initiated with all nursing /25/18. This education was Practice Educator and Unit ompleted with all facility staff glect/ injuries of unknown a education were the (bruising, fractures, skin right to be free from these ducation the staff were facility had had a major jin. This education was not completed on 6/25/18. Ompleted for all staff by the tor and Unit Manager. will be investigated in to ensure resident safety ions are completed. whoard (which shows all shange in condition note) will morning meeting. Incident intained electronically in the stem) will also be reviewed g Meeting by the Nursing etermine if there have been ers and/or their designees g rounds three times a week indling (care being provided,	{F 6	00}			

If continuation sheet Page 20 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 07/13/2018 1 APPROVED 2: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_	R· 07/	-C 02/2018
NAME OF PF	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
MOODEON			5	50 GLENWOOD DRIVE			
WOORES	ILLE CENTER		N	MOORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
{F 600}	Continued From page Nursing will be respon DON started 6/25/18. " The Administrato also randomly review and electronic inciden determine if there are investigation and if so investigation is compl process will be follow Assurance and Perfor Committee determine " All investigations Administrator and the that injuries are invest determine cause. " The Interim/Repla or Regional Nurse wil minimum frequency o Handling for care beir conducted to ensure of serious injuries. This 6 6/08/18 and conclude " The Interim/Repla and Administrator will members weekly to de the definitions of resid them, and the residen these injuries. These The Quality Assuranc Improvement Commit 6/22/18 to discuss the	a 20 asible for oversight. Interim r and Regional Nurse will the PCC Clinical Dashboard t reports weekly to any injuries that require an , ensure that an eted accordingly. This ed until the Quality mance Improvement s otherwise. will be reviewed by the Regional Nurse to ensure tigated thoroughly to acement Director of Nursing also randomly audit (with a f 5x/month) Safe Resident to provided and transfers residents are free from education was started on d on 6/25/18. acement Director of Nursing randomly question 10 staff etermine their knowledge of lent injuries, how to report ts right to be free from audits will begin on 6/26/18. e and Performance tee met on findings identified during this Action plan. The Quality	{F 600}				
	Committee will review compliance with the p The Administrator is re with this plan of correct	lan. esponsible for compliance					

Facility ID: 923353

If continuation sheet Page 21 of 53

		D HUMAN SERVICES MEDICAID SERVICES				FORI	D: 07/13/2018 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345283	B. WING				R-C / <b>02/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES	/ILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 600}	Continued From page provided by the Regic Operations and/or the Alleged date of remov Jeopardy: June 26, 20 The allegation of imm was verified on 07/02. Interviews with nursin revealed that they had protecting residents fr injury. The interviews would immediately region bruises to their immed verified the resident w Interviews with nursin had been educated of belt, mechnical lift, an correct number of star where each residents and how to access the instructed to report an transfer status to the of Interviews with nursin the unit managers rev conduct walking round	e 21 onal Vice President of e Regional Nurse. val of the Immediate 018 ediate jeopardy removal /18 as evidenced by: g staff and non nursing staff d been educated on rom harm and significant also revealed that staff port any injuries including diate supervisor once they vas safe. g staff revealed that they n safe transfers, using gait d sit to stand lift with the ff. They were educated on transfer status was located e information and were by changes in a residents nurse immediately. g administration including vealed that they would ds 3 times a week to make		600}	DEFICIENCY)		
	would review the 24 h morning along with th in the electronic medi reportable injury to en and thoroughly invest	ews also revealed that they your nursing report each e clinical dashboard located cal record to identify any usure that it was promptly					

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORMA	APPROVED 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SU COMPLE R-C	URVEY ETED
		345283	B. WING		-	2/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES				550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETION DATE
{F 600} {F 607} SS=D	had been educated o investigation that inclu- staff, any involved pe Medical Doctor, reach agency, and timely re- interview also revealed be provided by the fa- team to ensure comp Review of the educate educate staff between was made which inclu- policy and procedure, plan, and assignment interviewed had atten indicated that on a fa- Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The faciliti implement written pol §483.12(b)(1) Prohibi neglect, and exploitate misappropriation of re- §483.12(b)(2) Establist to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on observatio hospital Medical Doct interviews the facility abuse policy and proc	n conducting a thorough uded talking to residents, rson, reaching out to the ning out to the appropriate porting. The Administartor ad the oversight that would cility's corporate managment liance. ional material used to n 06/08/18 and 06/25/18 uded the facility's abuse review of the residents care sheets. Each staff member ded the education and cility sign in sheet. buse/Neglect Policies -(3) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures	{F 60		glect	7/2/18

Event ID: BJDN12

Facility ID: 923353

If continuation sheet Page 23 of 53

PRINTED: 07/13/2018

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	IO. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	CON	<b>IPLETED</b>
		0.45000				R-C
		345283	B. WING			7/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
MOORES	VILLE CENTER			550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIOI DATE
{F 607}	Continued From pag	e 23	(E 607	n		
{i 007}		vestigate an injury of	{F 607	•	tion and failed to	
		failed to report the injury to		involved during investiga adequately and thorough		
		ency within 2 hours for 1 of 3		cause of injuries, putting		
		Resident #1). Resident #1		at risk, and delayed in ol		
		ave a significant bruising with		information from the ER	and delay in	
		st area and right upper/inner		medical director involver		
		as not able to determine the		1 no longer resides at th	is facility.	
		The resident was admitted		2 All regidents have not	antial to be	
	injuries which include	aluation and treatment of his		2. All residents have pot effected. Unit Managers		
	-	on of blood outside the blood		Nurse reviewed all incide	-	
		ntusion (a type of hematoma		interviewed alert and ori	•	
	in which blood has e	scaped from ruptured		determine if any subseq	uent injuries of	
		e to trauma), and a mild		unknown origin had occu		
		mpression fracture of T12		none were identified. No		
	(thoracic spine).			Residents on Resident # assessed during investig		
	This deficiency was o	cited as an ongoing		determine if any injuries	-	
		on the complaint survey of		the Director of Nursing a Managers, with no signif	and Unit	
	allegation on 06/26/1	8 and it was accepted on			-	
		as conducted on 07/02/18				
		had removed the immediate		" The Director of Nursing		
		/26/18. The scope and		placed on administrative		
		ency was lowered to a D al harm with potential for		6/8/2018 due to failure to thorough investigation, f		
	· ·	arm that is not immediate		staff members and prote		
		om the original survey of		residents and failure to c		
		rought forward to reflect the		investigation. The Direct		
		diate jeopardy, and ensure		terminated effective		
		re inserviced, interventions		June 25, 2018. Interim E		
	were put in place, an	d monitoring was effective.		in place and has been e	-	
	The findings include	d:		Regional Nurse on the F Procedure for investigati included how to complet	ions. Education	
	A review of the facilit	y's Abuse Prohibition policy		(includes interviewing st		
		read in part, upon receiving		assessing residents) inv		
		ng a report of suspected or		according to policy and r	-	
				included was abuse prev		1

Facility ID: 923353

If continuation sheet Page 24 of 53

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
					R-C
		345283	B. WING		07/02/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
MOODES	VILLE CENTER			550 GLENWOOD DRIVE	
MOORES				MOORESVILLE, NC 28115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETIC
{F 607}	Continued From page	e 24	{F 607	71	
( )	1.0	ector (CED/Administrator) or	[1 00]	protecting residents from injury.	
		the following: initiate an		Administrator was also educated	on the
		4 hours of an allegation of		above by the Regional Nurse.	
		n: whether abuse or neglect			
		extent, clinical examination		" Staff were re □educated, Begin	
		indicated, causative factors,		6/08/18 and completed on 6/25/1	5
		prevent further injury. The		Nurse Practice Educator on the F	
		allegations involving neglect,		Policy for Abuse and Neglect and	
		atment (including injuries of		mandated reporting of allegations	
	unknown source) and			abuse to include injuries of unkno	
		later than 2 hours after the the event results in serious		origin to the Administrator, Direct	
		blicy further read, the center		Nursing or the employees immed supervisor. This re-education als	
		om further harm during an		included removing suspected em	
		review of the policy read,		from duty pending investigations	
	-	I to have committed the act		resident(s) while the investigation	-
		ediately removed from duty,		completed.	
	pending investigation	-			
				3.	
	Resident #1 was read	dmitted to the facility on		" The Administrator will ensure al	l future
		ses that included: dementia		allegations of Abuse & Neglect/In	juries of
		sturbances, history of		unknown origin are thoroughly	
		ach (mini stroke), and		investigated following policy and	
	weakness.			regulation to include suspension	
	Dovious of the most -	and quartarly Misira		suspected employees. The Admi	
		ecent quarterly Minimum d 05/16/18 revealed that		will achieve this by reviewing the reports that may include abuse/n	
		erely cognitively impaired		and injuries of unknown origin, ar	
		ve assistance of 2 staff		subsequent investigations, meeti	
	members with bed m			staffing coordinator and/or response	
	dressing.			department head to ensure staff	
				involved/suspected have been	
	Review of an Initial A	llegation Report dated		suspended. This process will beg	jin 🛛
	05/25/18 at 6:30 PM,	•		6/25/18 and will continue until the	
		ed that Resident #1 had an		Assurance and Performance	
		urce that included bruises to		Improvement Committee determi	ne
		ht upper/inner arm. The		otherwise.	
		the injury had been reported cement agency on 05/25/18		" PCC Clinical Dashboard (which all patients who have a change ir	

Facility ID: 923353

If continuation sheet Page 25 of 53

		MEDICAID SERVICES		LE CONSTRUCTION		<u>10. 0938-03</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	MPLETED
			A. DOILDING			R-C
		345283	B. WING			7/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
				550 GLENWOOD DRIVE		
MOORES	VILLE CENTER			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
{F 607}	Continued From page	a 25	{F 607	n		
1 0075			{F 607	-	ad in the	
		used employees were listed (NA) #1, #2, and #3. The		condition note) will be review clinical morning meeting. Inc		
		that it had been faxed to		(which are maintained electro		
		ency on 05/25/18 at 9:46 PM.		Risk Management System) in		
		,		Morning Meeting by the Nurs		
	Review of a 5-workin	g day report dated 06/01/18		Leadership team to determin		
	read in part, Residen	t #1 had been investigated		have been any new injuries.		
		r purple bruising to right		" The Unit Managers will do r		
		medial side with purple		walking rounds three times a		
		al chest. The report indicated		monitor resident handling (ca	-	
		been reported to local law		provided, transfers being cor		
		working day report included NA #1, #2, and #3. The		properly) to ensure residents abuse/serious injuries. These		
		art, "other residents on the		under the direction of the Ad		
		I and none had issues with		and any discrepancies will be		
		sments completed on the unit		him for review. If the Adminis		
	with no further injurie	•		available, the Interim/Replac		
	assigned to Resident	#1 on 05/25/18 were		Director of Nursing will be re-	sponsible for	
	interviewed and none	e of the staff were aware that		oversight.		
		sing to right inner arm and		" The Administrator and Regi		
	-	nt #1 was a 1-2 person		will also randomly review the		
		sfers. His skin was frail and		Dashboard and electronic inc		
		m protectors to decrease the		weekly to determine if there a	-	
		ncident was reported to the dical Doctor (MD). There was		injuries that require an invest so, ensure that an investigati		
		e in this case." No cause of		completed accordingly. This		
		identified. The 5-working		be followed until the Quality		
		to the State Survey agency		and Performance Improvement		
	on 06/01/18 at 1:49 F			Committee determines other		
				" All investigations will be rev	iewed by the	
		ssignment schedule for		Administrator and the Regior		
		at NA #4 cared for Resident		ensure that policy and regula		
		05/24/18 to 7:00 AM on		carried out to include the pro		
		ed for Resident #1 from 7:00		residents and prompt, thorough in		
		5/25/18, NA #3 cared for		investigations. A thorough in will include interviews of staf		
		00 AM to 3:00 PM on ed for Resident #1 from 3:00		residents, assessments of re		
		6/25/18, and NA #5 cared for		as indicated appropriate noti		
	······································		1			

Facility ID: 923353

If continuation sheet Page 26 of 53

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER AND PLAN OF CORRECTION COMPLETED A. BUILDING R-C 345283 B. WING 07/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE CENTER MOORESVILLE, NC 28115 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 607} Continued From page 26 {F 607} the Emergency Room (ER) on 05/25/18. Services, and timely reporting to the state agency (DHHS). An interview was conducted with NA #1 on 06/08/18 at 11:13 AM. NA #1 confirmed that she had cared for Resident #1 on 05/25/18. She 4. The results of the above audits and stated that on 05/30/18 the Director of Nursing monitoring will be brought before the (DON) had asked her for a written statement **Quality Assurance and Performance** about what had occurred with Resident #1 on Improvement Committee monthly to 05/25/18 and she had done so. She added that ensure compliance with plan. The she continued to work her regularly scheduled Regional Nurse will review and/or attend assignment with no change to her scheduled QAPI Meeting monthly. duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin. " The Administrator is responsible for compliance with this plan of correction, An interview was conducted with NA #2 on with oversight provided by the Regional 06/06/18 at 11:26 AM. NA #2 confirmed that she Vice President of Operations and/or the cared for Resident #1 on 05/25/18. She stated Regional Nurse. that on 05/28/18 the DON had asked her for a written statement about what had occurred with " Alleged date of compliance: July 2, 2018 Resident #1 on 05/25/18 and she had done so. She added that she continued to work her regularly scheduled assignment with no change to her scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin. An interview was conducted with NA #3 on 06/06/18 at 11:45 AM. NA #3 confirmed that he cared for Resident #1 on 05/25/18. He stated that on 05/31/18 the DON had asked him for a written statement about what had occurred with Resident #1 on 05/25/18 and he had done so. He added that he continued to work his regularly scheduled assignment with no change to his scheduled duties and had no knowledge of how Resident #1 acquired the bruise/injury of unknown origin. An interview was conducted with NA #4 on 06/06/18 at 11:33 AM. NA #4 confirmed that she

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 27 of 53

PRINTED: 07/13/2018

CENTER	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	LE CONSTRUCTION	FORM	D: 07/13/2018 APPROVED D: 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /			COMP	LETED
		345283	B. WING				-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	·	
MOODES	VILLE CENTER				550 GLENWOOD DRIVE		
WOORES				1	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	to 7:00 AM on 05/25/ cared for him and was NA #4 stated that the about the bruises disc she was not asked to added that she contin scheduled assignmen scheduled duties and Resident #1 acquired unknown origin. An interview was con- 06/06/18 at 3:50 PM. cared for Resident #1 until his was discharg stated that after she co bruises to Resident # #1 the DON had asked she was not asked to added that she contin scheduled assignmen scheduled assignmen scheduled duties and Resident #1 acquired unknown origin. An interview was con- 06/07/18 at 5:38 PM. 05/25/18 she reported AM and 11:00 AM and unit Resident #1 resid between 4:00 PM and break room having a were in there talking a Resident #1 and they picked him up and pu stated later there was Resident #1's room a	from 11:00 PM on 05/24/18 18 and that she routinely s familiar with his needs. DON did not speak to her covered on Resident #1 and write a statement. She nued to work her regularly at with no change to her had no knowledge of how the bruise/injury of ducted with NA #5 on NA #5 confirmed that she on 05/25/18 from 5:00 PM ed to the hospital. She discovered the dark purple 1 and reported it to Nurse ed her what happened but write a statement. She nued to work her regularly at with no change to her had no knowledge of how the bruise/injury of ducted with NA #8 on NA #8 stated that on d for her shift between 10:30 d was working on the same	{F (	607]	}		

If continuation sheet Page 28 of 53

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE COMF	SURVEY PLETED
		345283	B. WING				-C <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	02/2010
					550 GLENWOOD DRIVE		
MOORES	VILLE CENTER				MOORESVILLE, NC 28115		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 607}	NA #3 and NA #1 and your own business." It returned to her assign anything else about wi heard and no one ever incident and she was statement. She added her regularly scheduk change to her scheduk knowledge of how Reb bruise/injury of unknow An interview was com 06/06/18 at 4:12 PM. had no idea how the find Resident #1 did not m injuries to himself but possible that he was of stated that NA #8 was what happened and the business and get bac reported to me that sh #1 talking about dropp An interview was com- family member on 06/ stated that on 05/25/1 she received a phone her that they had four Resident #1's right an family member stated to the facility to see the added that when she described as dark pur extending over to his she also noted a large	"maybe you should talk to" d the NS told NA #8 "to mind NA #8 stated after that she ment and did not say what she had been told and er questioned her about the not asked to give a d that she continued to work ed assignment with no uled duties and had no esident #1 acquired the wn origin. ducted with the NS on The NS stated she honestly bruises occurred and stated hove enough to cause those added "it was very well dropped." The NS also is asking questions about rying to get involved in the er she needed to mind her k to work but she never he had heard NA #3 and NA ping Resident #1. ducted with Resident #1's (/06/18 at 9:48 AM. She 18 at approximately 6:30 PM e call from the facility telling	{F (	507)			

Facility ID: 923353

If continuation sheet Page 29 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/13/2018 APPROVED 0. 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_		-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
MOORES	/ILLE CENTER			550 GLENWOOD DRIVE MOORESVILLE, NC 28 <sup>4</sup>	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	don't know what happ stated she contacted around 6:45 PM and t and they asked what #1. The family memb law enforcement ques again they replied, "w happened." The intervi- law enforcement them Services (EMS) and F to the local hospital. An observation of Res local hospital on 06/0 #1 was resting in bed alert and incoherently extensive dark purple- right upper chest area the bruising extended had turned to a yellow The right upper arm a bruising that extended around the upper arm his left side and dark to the right chest area have facial grimacing turning and reposition his pain level. An interview was cond Medical Doctor (HMD The HMD stated that Resident #1 to the ho took over his case on that when he first met	ened and they replied, "we bened." The family member the local law enforcement at they responded to the facility had happened to Resident ber stated she directed the stions to the facility and e don't know what view further revealed local called Emergency Medical Resident #1 was transferred sident #1 was made in the 7/18 at 3:50 PM. Resident with eyes open, he was verbal. There was bruising noted from the a down to his right hip area, across the abdomen but v color across the abdomen. Iso contained purple d approximately 3 inches b. Resident #1 was noted to while being assisted with ed but was unable to voice	{F 607}				

Facility ID: 923353

If continuation sheet Page 30 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/13/2018 1 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING			R- 07/	-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
			5	50 GLENWOOD DRIVE			
MOORES	/ILLE CENTER		N	OORESVILLE, NC 2811	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
{F 607}	transfer may have cau further explained that chest scan that revea (a collection of blood and lung contusion (a blood has escaped fro usually due to trauma bumping into somethi the lung contusion. Th a pretty strong force to and he believed from Resident #1 may have that he sees lung con accidents or in the elo bed and are not cogn hands down to break stated that the protrus chest was suspected but to confirm that he more extensive test a physically appropriate stated that the dark pr his injuries were new bruises start to turn ye were beginning to hea hard to say if his injur to Resident #'s age an he would say no. Review of a Chest sca on 06/05/18 revealed chest wall pectoralis f the skin), ill-defined le represent lung contus which blood has esca capillaries usually due	d his injuries but stated a used the bruising. The HMD after they performed a led a chest wall hematoma outside the blood vessels) type of hematoma in which om ruptured capillaries ) he determined that ng could not have caused he HMD stated it would take o cause the lung contusion his injuries it appeared that e been dropped. He added tusion a lot in motor vehicle lerly who have fallen out of itively aware to put their the fall. The HMD also sion on Resident #1's right to be a pectoral muscle tear would need to perform a nd Resident #1 was not e for that test. The HMD urple bruises indicated that or acute and that when the ellow that indicates that they al. He added that it would be ies were life threatening due nd over-all health but initially	{F 607}				

Facility ID: 923353

If continuation sheet Page 31 of 53

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 07/13/2018 1 APPROVED 2: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_	R- 07/	-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			5	50 GLENWOOD DRIVE			
MOORES	VILLE CENTER		L L	MOORESVILLE, NC 28 <sup>4</sup>	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	Continued From page	31	{F 607}				
	enforcement Detective Detective who was as that on 05/25/18 one the call made from Re- from the facility. He re- was made aware from happened to her fami stated that when the of the staff was unable to Resident #1 he called hospital. The Detective the ER and observed surprised by the apper and the extent of the ID pictures but that was He added that he woulf facility to talk to the st not had time to do so. An interview was con 06/08/18 at 1:09 PM. she conducted the involution bruise/injury of unkno started with the staff to 05/25/18 and then pro- full investigation. The listed NA #1, #2, and 5-working day report If schedule and cared for She confirmed that no individuals were susp 05/25/18 or during the confirmed that all 3 ac provided care to other following the bruise/in	arance of the dark bruises bruises. He added that he R doctor and obtained some all that he had time to do. Id be going back over to the aff at some point but had ducted with the DON on The DON confirmed that vestigation of Resident #1's wn origin. She indicated she hat cared for him on beceded from there with the DON confirmed that she #3 on the initial and because they were on the or Resident #1 on 05/25/18. one of the accused ended or reassigned on a investigation. She further					

Facility ID: 923353

If continuation sheet Page 32 of 53

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	IPLETED
						<b>२-</b> С
		345283	B. WING		07	/02/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	)E	
				550 GLENWOOD DRIVE		
WOORES	ILLE CENTER			MOORESVILLE, NC 28115		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CC		(X5) COMPLETIO
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		DATE
{F 607}	Continued From page	e 32	{F 607}			
	for staff immediately	on proper transfer and she				
		otecting the residents. She				
		unable to determine what				
		s bruise/injury but stated				
	• • •	d" and "someone knows"				
		they need to come forward.				
		she should have suspended als until she could determine				
		ccurred to make sure all the				
		cted. She added that she				
		to the hospital to determine				
		nt #1's injuries and confirmed				
	that she based her in	-				
	individuals that cared	for Resident #1 on 05/25/18				
	but acknowledged the					
		ed care to him that day and				
	she should have.					
	An interview was cor	nducted with the				
	Administrator on 06/0	08/08 at 11:36 AM. The				
	Administrator stated	that he was informed of				
	Resident #1's bruisin					
		PM and by the time he arrived				
	-	esident #1 had been sent to				
	the Emergency Room					
		<ol> <li>He stated that when he</li> <li>the had to gather the</li> </ol>				
		y he had to gather the and at that point he faxed the				
		rt to the State Survey Agency				
	•	was outside of the 2-hour				
	window but stated he	e reported it as quickly as he				
	could. He added that	t he also had not seen any				
	-	n taken by the family or the				
		t. The Administrator stated				
	-	e investigation to the DON				
		view the investigation until				
		he 5-working day report to ency on 06/01/18. The				

Facility ID: 923353

If continuation sheet Page 33 of 53

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIPI	E CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · /	IPLETED
						R-C
		345283	B. WING		0	7/02/2018
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
MOORES	VILLE CENTER			550 GLENWOOD DRIVE		
MOOREO			I	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
{F 607}	Continued From page	e 33	{F 607]	\$		
. ,	1.0	ad been reported to the				
	State Survey Agency	•				
		cking in areas" and "could				
		ugh" but at that time the				
		een faxed to the agency so eport. He further stated that				
		one that was caring for				
		5/18 when the injury occurred				
		laced on leave pending the				
	investigation. He ack					
		the facility on 05/25/18 and wed. The Administrator				
	-	ed the DON or anyone				
		tions to follow the facility				
	policy and thoroughly	-				
		ijury of unknown origin. He				
		xtent of Resident #1's				
		he was "man-handled or ot rule out abuse and the				
		s investigation left him with				
	-	ns. He added that because				
		e investigation he could not				
		s were protected and would				
		. The Administrator stated DON or anyone conducting				
		w the facility policy and				
	-	from further harm during the				
	-	The Administrator added that				
		the investigation and				
	-	tion himself to determine				
	facility.	uired his injuries while in the				
	-	ened investigation was made				
	on 06/20/18. The investigation of the line	estigation contained DON, NA #1, NA #2, NA #3,				
		Nurse #1, NS, and Nurse				
	#2 but contained no					

Facility ID: 923353

If continuation sheet Page 34 of 53

	MENT OF HEALTH AN					FOF	ED: 07/13/2018 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345283	B. WING				R-C 7/02/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES	VILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
{F 607}	the investigation read ability we have obtain interested parties invo cannot isolate the cau the individuals that we Resident #1 are not n forthcoming with ever of these individuals ar suspended from duty return to the building. <sup>1</sup> Review of a daily assi 06/20/18 indicated tha work from 7:00 AM to #3's time card confirm 06/20/18 from 7:15 AI of his time card indica 06/11/18, 06/12/18, 00 06/15/18. Review of the revealed that they had and had not returned An interview was conf Quality Specialist (CC The CQS stated that the reopened the investig concluded the investig CQS confirmed that N 06/20/18 and provider indicated that the Adn vacation and unavailar communicated to her revealed that NA a return to the facility to the investigation. The Administrator had det	I in part, "to the best of our ned new statements from the olved and as of today we use of the bruises. We feel ere involved with the care of necessarily being its of the day in question. All re agency staff and were on 06/08/18 and will not " ignment sheet dated at NA #3 was scheduled to 0 3:00 PM. Review of NA ned that he had worked on M to 3:01 PM, further review ated that he had worked on 6/13/18, 06/14/18, and ime card for NA #1 and #2 d clocked out on 06/08/18 to the facility to work. ducted with the Clinical QS) on 06/20/18 at 6:00 PM. the Administrator had gation on 06/08/18 and gation on 06/14/18. The NA #3 had worked on d care to the residents. She ninistrator was currently on able for interview but had that his investigation had cause of the bruises but he #1 and NA #2 could not o work for reasons other than e CQS indicated that the termined that NA #3 had not and allowed him to return to	{F 6	607}			

If continuation sheet Page 35 of 53

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345283	B. WING				-C <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					550 GLENWOOD DRIVE		
MOORES	VILLE CENTER				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	indicated that the invor returning to the facility for allowing NA #3 to The acting Administra- immediate jeopardy of The facility provided a compliance to remove which is described be June 26, 2018 Facility respectfully su of compliance for F 60 Abuse & Neglect/Injuit to Follow Policy to Pro Failure to Adequately 1. Timeline: "May 25, 2018 -R bruising on his right c right lower back. o Director of Nursin Center, assessed res staff members on dut ensured notification o o Physician ordere humerus and right shi completed and all we o Administrator cor 24-hour report to the o Resident's daugh have resident sent to enforcement was notif facility and filed a rep- police upon her arriva	usion of his investigation olved parties would not be y or what basis was made return to duty. ator was notified of the on 06/20/18 at 10:22 AM an acceptable allegation of e the jeopardy on 06/28/18 elow: ubmits the below allegation 07: ry of Unknown Origin/Failure otect Other Residents and Investigate. esident # 1 noted to have hest, right upper arm, and ng notified and came into the ident, spoke with several y(#1, #2, and #3) and of the physician. d x-rays of the ribs, right oulder which were re negative for fractures. mpleted and sent in the State. hter in facility and asked to the hospital. Local law ified and responded to the ort. (Daughter phoned the	{F 6	607	3		

Facility ID: 923353

If continuation sheet Page 36 of 53

		D HUMAN SERVICES				FORM	07/13/2018 APPROVED
STATEMENT (	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE COMPI	
		345283	B. WING		_	R- 07/	-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			5	50 GLENWOOD DRIVE			
MOORES	VILLE CENTER		N	MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	to discharge summary diagnosis included, A: Altered Mental Status Failure and tachycard summary he also had right chest wall and a ER documentation sta appear to be in any di discharged home unti tachycardia". This inf reviewed on 6/26/18. "Resident # 1 has "May 28th-June 1 interviewed of staff and alert and oriented res was conducted by the interviewed included 3. Director of Nursing interviewed alert and that they had not exper reported. Director of nur staff home during the "June 1, 2018 - In by the Director of Nur noted that she was un responsible party or is resident's injuries. Sh conclusions to the stat to the Administrator. "Facility unable to injuries or name a per "June 8, 2018 o Administrator re-to post survey, due to is investigation was han Nursing, in particular suspended, and the in thorough and delayed	y from hospital, his admitting spiration Pneumonia, , Chronic Respiratory lia. According to discharge diagnosis of Hematoma to Pectoralis Muscle Strain. ates that resident "did not istress, and was going to be l he had a run of ventricular formation obtained and not returned to the facility. st: Investigation included d agency staff, as well as idents. This investigation e Director of Nursing. Staff Staff Members # 1, #2 and # g stated that she had oriented residents to ensure erienced abuse/injuries. Not hursing failed to send any investigation. itial investigation concluded sing. In her conclusion she hable to identify a solate the cause of e reported these the on the 5 day report and determine the cause of rpetrator. opened the investigation sues with how initial dled by the Director of that no staff were nvestigation was not	{F 607}				

Facility ID: 923353

If continuation sheet Page 37 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/13/2018 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_	R· 07/	-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
				50 GLENWOOD DRIVE			
MOORES	/ILLE CENTER			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	the date of injury (4 ag #3, and #6) were rem 6/08/18. Staff member Regional HR to have #1 on 5/25/18, this wa time staff #4 was susy Staff #4 statement did information to the inver " June 14, 2018 - S concluded o Facility still unable Resident # 1 o Not able to detern directly involved. o Administrator det there of the agency st #6) from the schedule their statements, and untruthful from other as o The Nursing Age Administrator on June not want those three s return to the facility ur o Fourth nurse aided the schedule at the co by the Administrator a from 6/11/18 to 6/20/1 that this nurse aid had this resident on 5/25 a from another staff me aids noninvolvement. " Emergency Roor from 5/25/18 includes o Mild to moderate surface of right upper	nsible for this injury assigned to Resident # 1 on gency nurse aides: # 1, #2, noved from the schedule on r #4 was noted by the also worked with Resident as noted on 6/25, at which pended and interviewed. I not provide any additional estigation. Second investigation le to substantiate abuse for mine any staff member cided to permanently remove taff members (#1, #2, and e due to inconsistencies in reports of them being aide staff. ncy was notified by the e 8, 2018 that the facility did specific nurse aides to nder any circumstances. e (#3) was placed back on onclusion of the investigation and had worked six shifts 18. Investigation showed d not provided any care for and corroborating statement mber validates this nurse m Physician Documentation the following: ecchymosis over anterior arm. No notable bruising ack, which is contrary to the	{F 607}				

If continuation sheet Page 38 of 53

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/13/2018 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING			R- 07/	-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
			5	50 GLENWOOD DRIVE			
MOORES	/ILLE CENTER		I I	MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	on the phone, physici officer " I expressed in has a tear to his right subsequent hematom could have occurred of wheel chair and is not abuse, neglect or gros o The patient contin o I have done my b daughter) that we do needs treatment in the nursing care, which sit nursing home, is appr know that even if patie likely be discharged the agreed that we may re home. o This information of 6/26/18. " The Hospital Disc 6/17/18, when reside another SNF, states t o Resident not in a o He is stable for d o Discharge Diagno chest wall, improving. Pectoralis muscle stra o This information of 6/26/18. " Facility Medical D Physician documenta Discharge Summary f (had previously been statement in which he likely occurred during " June 20, 2018 -	nge of motion) obysician to speak to police an states that he told the ny opinion that the patient pectoralis muscle with i.a. I do believe that this during transfers from bed to t necessarily an indication of ss negligence" nues to rest peacefully best to explain to her (the not see any condition that e hospital and ongoing hould be provided in the opriate. I let the daughter ent were admitted, he would ne next day, the daughter eturn him to the nursing was obtained and reviewed charge summary from nt was discharged to he following: ny distress. ischarge to SNF osis: Hematoma of right Tachycardia resolved, and ain stable. was obtained and reviewed Director, reviewed the ER tion as well as the for Resident # 1, on 6/26/18 on vacation) and provided a e indicates that the injury	{F 607}				

Facility ID: 923353

If continuation sheet Page 39 of 53

	-	ID HUMAN SERVICES				FORM	07/13/2018 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION		(X3) DATE COMPI	
		345283	B. WING		_	R- 07/0	-C 02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				550 GLENWOOD DRIVE			
MOORES	VILLE CENTER			MOORESVILLE, NC 281	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	agency was notified, of staff member involved no documentation as returned him to scheo available this date). " Administrator has multiple messages to investigation, the Invec calls. Friday 6/15 and " Facility failed to f resident(s) by not sus failed to adequately a the cause of injuries, risk, as evidenced by information from the E director involvement. This conclusion was r Administrator and Me vacation from 6/15-6/2 made contact with the information. 2. Actions Taken " The Director of N on administrative leav to complete a thoroug suspend staff member resident/other resident timely investigation. T not be returning to the terminated effective J " Staff were re-edu and completed 6/25/1 Educator and Unit Ma reporting of abuse an	ermanently and the staffing due to his being named as a d in initial investigation , and to why Administrator had dule (Administrator not s left Police Investigator discuss the outcome of his estigator has not returned I Tuesday 6/26/18. follow policy to protect spending staff involved and nd thoroughly investigate putting other residents at delay in obtaining ER and delay in medical made 6/26/18.The dical Director were on 24, and had not previously e hospital for this lursing Services was placed ve on 6/8/2018 due to failure gh investigation, failure to ors and protect nts and failure to complete a The Director of Nursing will e facility and will be une 25, 2018. ucated, beginning on 6/08/18 8 by Nurse Practice anagers on mandated d neglect/ injury of unknown ction of the resident(s) by d employees and	{F 607	}			

Facility ID: 923353

If continuation sheet Page 40 of 53

D HUMAN SERVICES MEDICAID SERVICES				D: 07/13/20 MAPPROVE D. 0938-039
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			PLETED
345283	B. WING			-C /02/2018
	STR	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
pened by the Administrator awed by the Administrator to allegations of abuse. investigation was not able of resident # 1's injuries. and Regional Nurse reviewed d interviewed alert and determine if any subsequent igin had occurred, on entified. e Residents on Resident # 1 uring investigation, to es were present, by the d Unit Managers, with no ator and Unit Managers 0/18 by the Regional Nurse ons on Abuse Prevention ats from injury. Education complete a thorough staff, residents, assessing on according to policy and rator is to return on 6/25/18 e re-educated by the ultant on the above, along of Nursing. B/18 and completed on /ees were re-educated by ucator on the Facility Policy t and mandated reporting of o include injuries of Administrator, Director of rees immediate supervisor. o included removing	{F 607}			
	IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE C         345283       B. WING         345283       B. WING         STE       550 MC         VILL       STE         YEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)       ID PREFIX TAG         40       {F 607}         ewed by the Administrator       ewed by the Administrator to allegations of abuse. investigation was not able to fresident # 1's injuries. nd Regional Nurse reviewed d interviewed alert and betermine if any subsequent igin had occurred, on entified.         e Residents on Resident # 1 uring investigation, to es were present, by the id Unit Managers 0/18 by the Regional Nurse ons on Abuse Prevention nts from injury. Education complete a thorough staff, residents, assessing on according to policy and rator is to return on 6/25/18 e re-educated by the ultant on the above, along of Nursing. 8/18 and completed on yees were re-educated by lucator on the Facility Policy t and mandated reporting of o include injuries of Administrator, Director of yees immediate supervisor. o include removing from duty pending	(X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         JDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION         A BUILDING	(X1) PROVIDERSUPPLERICLA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE         345283       B. WING       R         345283       B. WING       07         STREET ADDRESS, CITY, STATE, ZIP CODE       SS GLENWWOOD DRIVE       07         MORESVILLE, NC 28115       D       PROVIDERS PLAN OF CORRECTION       07         VIEMENT OF DEFICIENCIES       D       PROVIDERS PLAN OF CORRECTION SHOLD BE       07         CIDENTIPYING INFORMATION)       TAG       PROVIDERS PLAN OF CORRECTION SHOLD BE       07         40       (EACH CORRECTIVE ACTION SHOLD BE       CROSS-REFERENCE OF APPOPRIATE       DEFICIENCY         40       (F 607)       PROVIDERS PLAN OF CORRECTION SHOLD BE       CROSS-REFERENCE OF APPOPRIATE       DEFICIENCY         40       (F 607)       FG07       PROVIDERS PLAN OF CORRECTIVE ACTION SHOLD BE       CROSS-REFERENCE OF APPOPRIATE         aved by the Administrator to       Illegations of abuse.       Investigation to       Street Corrective APPOPRIATE         aved alert and directive add alert and directive add alert and steaming investigation, to       Street Corrective APPOPRIATE       DEFICIENCY         ator and Unit Managers       0/18 by the Regional Nurse ons on Abuse Prevention nots for action of C25/18 and completed on yees were re-educated by the ultant on the above, along of Nursing.       Nursing.       Nursing.

Facility ID: 923353

If continuation sheet Page 41 of 53

	-	ID HUMAN SERVICES				FORM	07/13/2018 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			(X3) DATE COMP	
		345283	B. WING		_	R· 07/	-C 02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	011	02/2010
				550 GLENWOOD DRIVE	,		
MOORES	VILLE CENTER			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	re-education. Educat definitions of abuse, a tolerance" policy. 3. Action Items: "Beginning on 06/ staff will be educated the resident care area Educator on the Facil Neglect/ injuries of un reporting of allegation neglect to the Adminis Director of Nursing or Supervisor. This edu removing suspected of pending investigation is co Educator or Unit Man Agency staff on the al scheduled agency staf education) "Administrator and Director of Nursing we Regional Nurse Cons regulations on Abuse residents from injury. how to complete a the interviewing staff, res and thorough investig and regulations, prior This education was co "The Administrato allegations of Abuse a unknown origin are th following policy and resuspension of any su Administrator will ach incident reports that m	25/18, all newly hired facility prior to beginning work in a by the Nurse Practice ity Policy for Abuse and aknown origin and mandated as of resident abuse and strator, Interim/Replacement the employee's immediate cation will also include employees from duty to protect resident(s) while ompleted. Nurse Practice ager will educate all new bove. (All currently aff have received this d Interim/Replacement ere re-educated by the sultant related to the Prevention and protection Education will also include prough (includes idents, assessing residents) pation according to policy to their returning to work. ompleted on 6/25/18. or will ensure all future & Neglect/Injuries of noroughly investigated	{F 607	n			

Facility ID: 923353

If continuation sheet Page 42 of 53

	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		O. 0938-03
	F CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	IPLETED
			A. DOILDING			R-C
		345283	B. WING			7/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
				550 GLENWOOD DRIVE		
MOORES	VILLE CENTER			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
		- 10	(= 0.01			
{F 607}	1.0		{F 607	'}		
		ng with staffing coordinator				
		epartment head to ensure				
		ted have been suspended.				
	This process will begin 6/25/18 and will continue until the Quality Assurance and Performance					
	-	ttee determine otherwise.				
	· ·	shboard (which shows all				
		•				
		change in condition note) will inical morning meeting.				
	Incident reports (which					
		Risk Management System) in				
		Meeting by the Nursing				
	-	letermine if there have been				
	any new injuries.					
		ers will do random walking				
	-	week to monitor resident				
		provided, transfers being				
		to ensure residents are free				
		njuries. These rounds are				
		f the Administrator, and any				
		reported to him for review. If				
	the Administrator is n	-				
		Director of Nursing will be				
	responsible for overs					
		or and Regional Nurse will				
		the PCC Clinical Dashboard				
	and electronic incide					
		any injuries that require an				
	investigation and if so					
		leted accordingly. This				
	process will be follow	ed until the Quality				
	Assurance and Perfo	rmance Improvement				
	Committee determine					
	-	s will be reviewed by the				
		e Regional Nurse to ensure				
		ations were carried out to				
		n of residents and prompt,				
	thorough investigatio	ns. A thorough investigation				
		s of staff and residents,				

Facility ID: 923353

If continuation sheet Page 43 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345283	B. WING			-C <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES	VILLE CENTER			50 GLENWOOD DRIVE IOORESVILLE, NC 28115		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 607}	Continued From page	243	{F 607}			
		ents, and as indicated	( ,			
		n to enforcement and Adult				
	Protective Services, a state agency (DHHS)	and timely reporting to the				
	The Quality Assuranc	e and Performance				
	Improvement Commit	tee met on				
		e findings identified by the this action plan. The Quality				
	Assurance and Perfor					
	Committee will review compliance with this p					
	The Administrator is r with this plan of corre provided by the Regio Operations and/or the	onal Vice President of				
	Alleged date of remov Jeopardy: June 26, 20					
	The allegation of imm	ediate jeopardy removal				
	was verified on 07/02	/18 as evidenced by:				
	Interviews with nursin	g staff and non nursing staff				
	revealed that they had	d been educated on the				
	· ·	eglect policy and procedures				
		ng residents from harm and interviews also revealed				
		diately report any injury				
		eir immediate supervisor				
	once they verified the	resident was safe.				
	Interviews with nursin	g staff revealed that they				
	had been educated o	n safe transfers using a gait				
		d sit to stand lift with the				
		ff. They were educated on transfer status was located				
		e information and were				

Facility ID: 923353

If continuation sheet Page 44 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 07/13/2018 // APPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345283	B. WING				-C <b>02/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MOORES	/ILLE CENTER				50 GLENWOOD DRIVE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
{F 607}	Continued From page instructed to report ar transfer status to the Interviews with nursin that they would condu- week to make sure st handling/transferring also revealed that the nursing report each m clinical dashboard loc medical record to ider ensure that it was pro- investigated. Interview with the Adr Director of Nursing re educated on conducti that included talking to involved person, reac Doctor, reaching out to and timely reporting, also revealed the ove provided by the facilit team to ensure comp Review of the educati educate staff betweer was made which inclu- neglect policy and pro- residents care plan, a	e 44 hy changes in a residents nurse immediately. In a gadministration revealed uct walking rounds 3 times a aff was safely residents. The interviews ey would review the 24 hour norning along with the cated in the electronic nutify any reportable injury to omptly and thoroughly ministrator and Interim evealed that they had been ing a thorough investigation o residents, staff, any ching out to the Medical to the appropraite agency, The Administartor interview resight that would be y's corporate managment liance. ional material used to n 06/08/18 and 06/25/18 uded the facility's abuse and	{F 6	07}			
{F 835} SS=D	education and indicat sheet. Administration CFR(s): 483.70	ed that on a facility sign in	{F 8	35}			7/2/18
	§483.70 Administration A facility must be adm	on. ninistered in a manner that					

Facility ID: 923353

If continuation sheet Page 45 of 53

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	TIPLE CONSTRUCTION	(X3) DA	IO. 0938-039 E SURVEY PLETED
	CONNECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG		R-C
		345283	B. WING			R-C 7/02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
MOORES	VILLE CENTER			550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
{F 835}	Continued From page	e 45	{F 8	335}		
	efficiently to attain or practicable physical,	mental, and psychosocial				
This REC by: Based of hospital interview provide l resident origin an determin	by:	n, record review, family,		F 835 Administration		
	interview the facility A provide leadership ar	tor, Detective and staff Administration failed to ad oversight to protect a icant injury of unknown		1. The facility Administration provide leadership and ove protect a resident from a sig	rsight to	
	origin and conduct a determine the cause,	thorough investigation to failed to implement their tect the residents during and		of unknown origin and cond investigation to determine the failed to implement their ab	luct a thorough he cause,	
	after the investigation significant injury to th	a, and failed to report the e state survey agency within idents sampled (Resident		protect the residents during investigation, and failed to r significant injury to the state	and after the report the	
	#1). Resident #1 was to have significant bro	discovered by facility staff uising to his upper torso unknown. The resident was		agency within 2 hours for R Resident # 1 no longer resident facility. Administrative staff	esident # 1. des at this	
	sent to the hospital for and was diagnosed w	or evaluation and treatment vith a compression fracture		and Director of Nursing) bo roles in the last year. Admi	th new to their inistrative staff	
	contusion.	all hematoma, and left lung		failed to involve Corporate enough detail of this signific allow for appropriate assista	cant event, to	
	This deficiency was c immediate jeopardy c 06/20/18. The facility	on the complaint survey of		guidance on the process. 2. All residents have potent	ial to be	
	allegation on 06/26/1 06/28/18. A revisit wa	8 and it was accepted on as conducted on 07/02/18		effected. Regional Nurse re incident reports to determin	eviewed all le if any	
	jeopardy effective 06, severity of this deficie	had removed the immediate /26/18. The scope and ency was lowered to a D		subsequent injuries of unkn occurred, on 6/08/18, with r During this review Regional	none identified. I Nurse also	
	more than minimal ha jeopardy). The text fro	al harm with potential for arm that is not immediate om the original survey of		audited for any other signifi- none were noted.		
	removal of the immed	rought forward to reflect the diate jeopardy, and ensure re inserviced, interventions		" The Director of Nursing So placed on administrative lea 6/8/2018 due to failure to co	ave on	

Facility ID: 923353

If continuation sheet Page 46 of 53

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	ATE SURVEY OMPLETED
			A. BUILDING			
		345283	B WING			R-C
		345283	B. WING			07/02/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE	E	
MOORES	ILLE CENTER			550 GLENWOOD DRIVE		
				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
{F 835}	Continued From page	e 46	{F 835	3		
		d monitoring was effective.		thorough investigation, failure	to suspend	
				staff members and protect re-		
	The findings included	l:		residents and failure to comp		
	-			investigation. The Director of	•	
	1. This tag is cross	referred to F600:		not be returning to the center		
				Nursing has also been report		
		n, record review, family,		Board of Nursing by Regiona Consultant on 6/22/18.	INUISE	
i 1 :	•	tor, Detective and staff failed to protect a resident		" The Administrator and Direc	tor of	
		ry of unknown origin for 1 of		Nursing were educated by the		
		(Resident #1). Resident #1		Nurse related to the regulatio	-	
		ve a bruise to his right arm		Prevention and protection res		
	and chest and was se	ent to the Emergency Room		injury. Education also include	ed how to	
		red he also had a right chest		complete a thorough investig		
		llection of blood outside the		(includes interviewing staff, re		
		ung contusion (a type of		assessing residents) accordin		
		lood has escaped from		and regulations. Education c	ompleted on	
		sually due to trauma), and a e compression fracture of		" Administrator and Interim D	irector of	
	T12 (thoracic spine).			Nursing were also educated I		
				Regional Nurse on process for	-	
	2. This tag is cross	referred to F607:		of Regional Team including R		
	-			Nurse and Regional Vice Pre		
		n, record review, family,		Operations, of significant eve		
	-	tor, Detective, and staff		center. This education include		
	•	failed to implement their		considered a significant even		
		cedures to protect residents		education was completed on	6/25/18.	
	failed to thoroughly in	d after the investigation,		3.		
		failed to report the injury to		" The Administrator will ensur	e all future	
		ncy within 2 hours for 1 of 3		allegations of Abuse & Negle		
		esident #1). Resident #1		unknown origin are promptly	-	
		ve a significant bruising with		following policy and regulatio	n to include	
		st area and right upper/inner		suspension of any suspected		
		as not able to determine the		The Administrator will achieve	-	
		The resident was admitted		reviewing the incident report		
	to the hospital for eva injuries which include	aluation and treatment of his		subsequent investigations, m staffing coordinator and/or re	-	

Facility ID: 923353

If continuation sheet Page 47 of 53

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	)	. ,	PLETED
					F	R-C
		345283	B. WING		07	/02/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
MOODES	VILLE CENTER			550 GLENWOOD DRIVE		
WOORES	VILLE CENTER			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
{F 835}	Continued From pag	e 47	{F 835	51		
[	1.0	ntusion (a type of hematoma	1 000	involved/suspected have	heen	
		scaped from ruptured		suspended. The Regiona		
		ie to trauma), and a mild		ensure this process of fol		
		mpression fracture of T12		conducting her own revie		
i	(thoracic spine).			Reports weekly with follow		
				Administration as indicate		
	A follow up interview	was conducted with the		will begin 6/25/18 and wil		
	•	08/18 at 7:01 PM. The		the Quality Assurance an		
		stated that he felt like the		Improvement Committee		
	-	Director of Nursing (DON)		otherwise.		
	-	not thorough and he had		" PCC Clinical Dashboard	d (which shows	
	decided to reopen th	e investigation and had		all patients who have a cl		
	already conducted se	everal interviews and		condition note) will be rev	viewed in the	
	obtained additional s	tatements. He added that at		Clinical Morning Meeting.	Incident reports	
	the time the 5-workin	ig day report had already		(which are maintained ele	ectronically in the	
	been sent to the Stat	e Survey Agency and "it was		Risk Management Syster	m) in the Clinical	
	over and done with a	and we were moving on." The		Morning Meeting by the N	Nursing	
		that once he learned of the		Leadership team to deter		
		esident #1 sustained he felt		have been any new injuri		
	like he needed to try			Regional Nurse will ensu	-	
		tainly expected the DON or		followed by her own revie		
		I to conduct the investigation		Dashboard and RMS sys		
	•	investigation and determine		electronic systems) week	-	
		the residents at the same		appropriate follow up with		
	-	was not done with this		Administrative Staff. Regi		
		strator also stated he would		also attend the Clinical M	0 0	
	expect the reporting			on scheduled bi-monthly	visits to monitor	
	completed within the	2-nour time trame.		the process.	injuny or obvice	
	The acting Administr	ator was notified of the		" In the event of a serious		
	-	ator was notified of the on 06/20/18 at 10:22 AM.		allegation, the Administra of Nursing will be notified		
		011 00/20/10 at 10.22 AW.		and will in turn notify the	-	
	The facility provided	an acceptable allegation of		and the Regional Vice Pr		
		re the jeopardy on 06/28/18		Operations to ensure that		
	which is described be			investigation is completed		
				" All investigations will be		
	June 26, 2018			Administrator and the Re		
				ensure that policy and re	-	
	1		1			1

Event ID: BJDN12

Facility ID: 923353

If continuation sheet Page 48 of 53

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	(X2) MULTIPLE CONSTRUCTION			
ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345283		A. BUILDING		(X3) DATE SURVEY COMPLETED R-C		
			R-0			
		B. WING			2/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
MOORESVILLE CENTER				550 GLENWOOD DRIVE		
				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
{F 835}	Continued From page	e 48	{F 835	5}		
		35: Administration-Failure to		residents and prompt, the	brough	
		prevent a resident from		investigations.	0	
	• •	d to protect residents from				
	future occurrences, a			4 The share ""		
	investigate these inju	ries thoroughly.		4. The above audits and reported to The Quality A	-	
				Performance Improveme		
	1. Facility Administr	rative Staff failed to protect		monthly to ensure compli		
	-	a thorough investigation for		plan. Regional Nurse will		
		ificant injuries of unknown		Assurance and Performa	-	
		staff (Administrator and		Improvement minutes mo	-	
		oth new to their roles in the		months to ensure complia	-	
	Corporate Team in er	tive staff failed to involve		Nurse will attend Quality Performance Improveme		
	significant event, to a	-		randomly over next 6 mo		
	assistance and guida					
	0	·		The Regional Team (Reg	ional Nurse and	
				Regional Vice President)		
	2. Actions Taken:			responsible for compliant	ce with this plan	
		lursing Services was placed		of correction.		
		ve on 6/8/2018 due to failure				
	suspend staff membe	gh investigation, failure to		Alleged date of compliant	ce: July 2, 2018	
	-	nts and failure to complete a			cc. buly 2, 2010	
		The Director of Nursing will				
		e center. Director of Nursing				
		ed to the Board of Nursing				
	by Regional Nurse Co					
		rator and Unit Managers 20/18 by the Regional Nurse				
		ons on Abuse Prevention				
		nts from injury. Education				
	will also include how	to complete a thorough				
	investigation (include	-				
		residents) according to				
		s. Administrator return to				
		was re-educated by the sultant on the above at that				
	time with Interim-Dire					

If continuation sheet Page 49 of 53

ENTERS FOR MEDI						0.0938-03	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345283       345283			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		A. BOILDING		R	R-C		
		B. WING		07/02/2018			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	102/2010	
				550 GLENWOOD DRIVE			
MOORESVILLE CENTER				MOORESVILLE, NC 28115			
PREFIX (EACH	MMARY STATEMENT OF DEFICIENCY MUST BE PF ATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
" Adminis were educat for notificatio Regional Nu Operations, This educati significant ev on 6/25/18. " Region to determine unknown ori none identifi	" Administrator and Interim Director of Nursing were educated by the Regional Nurse on process for notification of Regional Team including Regional Nurse and Regional Vice President of Operations, of significant events in the center. This education included what is considered a significant event. This education was completed		(F 835	5}			
allegations of unknown ori following pol suspension of Administrato incident repo meeting with responsible involved/sus Regional Nu followed by of Incident Rep Administratio	ninistrator will ensur f Abuse & Neglect/I gin are promptly inv icy and regulation to of any suspected en r will achieve this by ort and subsequent i staffing coordinato department head to pected have been s rse will ensure this conducting her own orts weekly with foll on as indicated. This 8 and will continue	njuries of estigated o include nployees. The y reviewing the nvestigations, r and/or ensure staff uspended. The process of review of the ow up with the s process will until the Quality					

Facility ID: 923353

If continuation sheet Page 50 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	тірі			5. 0936-0391 E SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED	
					·		R-C	
		345283	B. WING				/02/2018	
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE			
					550 GLENWOOD DRIVE			
MOORES	/ILLE CENTER				MOORESVILLE, NC 28115			
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTIO	1	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETION DATE	
TAG			TAG	J	DEFICIENCY)	JATE		
{F 835}	Continued From page	50	{F 8	225	5			
{i 000}			<u></u> (Γ C	550	10			
		Aeeting by the Nursing						
	-	etermine if there have been						
		e Regional Nurse will ensure ed by her own review of the						
		system (both electronic						
		appropriate follow up with						
		aff. Regional Nurse will also						
		prning Meeting on scheduled						
	bi-monthly visits to me							
	" In the event of a							
		istrator and Director of						
		d immediately, and will in						
	turn notify the Region	al Nurse and the Regional						
	-	erations to ensure that a						
	coordinated investiga	-						
		will be reviewed by the						
		Regional Nurse to ensure						
		tions were carried out to						
	-	of residents and prompt,						
	thorough investigation							
		l complete his onboarding ional Team via visits and						
	web based trainings.							
		I" and includes business and						
		rsing Home Administration.						
	· ·	ctor of Nursing will receive						
		ation by the Regional Nurse						
	upon start with facility	·. ·						
	The Quality Assuranc							
		ttee, with the Regional						
		met on 6/22/18 to discuss						
	•	by the survey and to review						
		Regional Vice President of						
		cility on 6/25 to conduct a						
	-	Plan of Correction. The						
	Quality Assurance an							
		ttee will review monthly to ith this plan. Regional Nurse						

If continuation sheet Page 51 of 53

PRINTED: 07/13/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 07/13/2018 M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE COMF	E SURVEY PLETED	
		345283	B. WING				R-C / <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
MOORES	VILLE CENTER				550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
{F 835}	will review Quality Ass Improvement minutes ensure compliance. R Quality Assurance and Improvement Commit months. The Regional Team (F Regional Vice Preside responsible for compl correction. Alleged date of remov Jeopardy: June 26, 20 The allegation of imm was verified on 07/02. Interviews with nursin revealed that they had facility's abuse and ne that including protectin significant injury. The that staff would immediate including bruises to the once they verified the Interviews with nursin had been educated on belt, mechnical lift, an correct number of staff where each residents and how to access the instructed to report an transfer status to the p	surance and Performance a monthly for 6 months to Regional Nurse will attend d Performance ttee randomly over next 6 Regional Nurse and ent of Operation are liance with this plan of val of the Immediate 018 rediate jeopardy removal /18 as evidenced by: ng staff and non nursing staff d been educated on the eglect policy and procedures ng residents from harm and interviews also revealed diately report any injury heir immeditate supervisor e resident was safe.	{F :	835}	}		

Facility ID: 923353

If continuation sheet Page 52 of 53

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/13/2018 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		345283	B. WING				-C <b>02/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		•	s	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOORESVILLE CENTER					550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 835}	sure staff was safely h residents. The intervie would review the 24 h morning along with the in the electronic media reportable injury to en- and thoroughly invest Interview with the Inter (DON) revealed that as the facility's abuse an process for conduction. The interview also rev- notifying the regional events in the center. Interview with the Adm revealed that they had conducting a thorough talking to residents, si reaching out to the Me to the appropriate age individuals, and timely Administartor interview oversight that would b corporate managmen compliance. Review of the educati educate staff between was made which inclu- neglect policy and pro- residents care plan, a Quality Assurance and Improvement Commit member interviewed b	ds 3 times a week to make handling/transfering ews also revealed that they nour nursing report each e clinical dashboard located cal record to identify any hsure that it was promptly igated. erim Director of Nursing she had been educated on d neglect policy and the g a thorough investigation. vealed her responsibility of corporate team of significant ministrator and DON d been educated on h investigation that included taff, any involved person, edical Doctor, reaching out ency, suspension of accused y reporting. The w also revealed the be provided by the facility's t team to ensure	{F :	835}			

Event ID: BJDN12

Facility ID: 923353

If continuation sheet Page 53 of 53