CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	0. 0938-0391
-	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE COMP	SURVEY PLETED
		345066	B. WING			06/28/2018	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					4748 OLD SALISBURY ROAD		
ALSTON E	BROOK				LEXINGTON, NC 27295		
(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)	BE	(X5) COMPLETION DATE
	Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility trans resident, the facility n (i) Notify the resident representative(s) of the the reasons for the m language and manne facility must send a corepresentative of the Long-Term Care Omt (ii) Record the reason discharge in the reside accordance with para and (iii) Include in the notif paragraph (c)(5) of the §483.15(c)(4) Timing (i) Except as specified (c)(8) of this section, discharge required ur made by the facility a resident is transferred (ii) Notice must be ma before transfer or disc (A) The safety of indi- be endangered under this section; (B) The health of indi-	Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The opy of the notice to a Office of the State budsman. Is for the transfer or lent's medical record in tigraph (c)(2) of this section; ice the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be t least 30 days before the d or discharged. ade as soon as practicable	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE
	allow a more immedia under paragraph (c)( (D) An immediate tran required by the reside under paragraph (c)(	ent's urgent medical needs, 1)(i)(A) of this section; or					
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURI	=	-	TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

07/20/2018

PRINTED: 08/01/2018

FORM APPROVED

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.

**Electronically Signed** 

# 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) 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) Continued From page 1 F 623 F 623 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice.

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345066	B. WING		06/28/2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
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F 623	Continued From pag		F 62	<ul> <li>(4) weeks, then on a monthly bas quarterly basis the Administrator report the findings and results to Quality Assurance committee for monitoring and recommended ch THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMEN THE ACCEPTABLE PLAN OF CORRECTION.</li> <li>The Administrator is responsible implementing the acceptable plan correction.</li> </ul>	will the anges. NTING for n of
F 625 SS=D	CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice nursing facility transfi the resident goes on nursing facility must i the resident or reside specifies- (i) The duration of the any, during which the return and resume re facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facili bed-hold periods, wh paragraph (e)(1) of th resident to return; an	bed-hold policy and return- before transfer. Before a ers a resident to a hospital or therapeutic leave, the provide written information to ent representative that e state bed-hold policy, if e resident is permitted to esidence in the nursing bayment policy in the state of this chapter, if any; ty's policies regarding ich must be consistent with his section, permitting a d specified in paragraph (e)(1)	F 62		7/26/18

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### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 625 Continued From page 10 F 625 resident's family regarding a bed hold after a later than July 26, 2018. Effective July 20, resident is discharged to the hospital. The MD 2018 The Bed Hold Policy and Consent stated the facility had not been providing written Agreement form was added to the Acute notification regarding the bed hold to resident's Care Transfer Document Checklist families when the resident was discharged to the indicating that the Form is to be hospital. completed and given to the resident or transported with the resident. The An interview was conducted on 6/28/18 at 5:35 Admission Coordinator or designee will PM with the Administrator, Director of Nursing maintain a file containing all Bed Hold (DON), AC, and MD. The Administrator stated he Policy and Consent Agreements that have and the staff were not familiar or aware a new been issued. In addition a copy of all regulation had taken effect as of 11/28/17 completed Bed Hold Policy and Consent regarding providing written notification to a Agreements will be placed in the Resident resident or their family for residents whom had medical record. been discharged to the hospital. The THE MONITORING PROCEDURE TO Administrator stated the facility had not been ENSURE THAT THE PLAN OF providing written notification to a resident's family CORRECTION IS EFFECTIVE AND or the resident themselves whom were THAT SPECIFIC DEFICIENCY CITED **REMAINS CORRECTED AND/OR IN** discharged to the hospital. COMPLIANCE WITH THE An interview was conducted on 6/28/18 at 7:24 REGULATORY REQUIREMENTS. PM with Resident #68's family. The family The Administrator or designee will be member stated she had not received written responsible to complete a Quality notification from the facility regarding a bed hold Assurance Review for accuracy and for the resident. The family member did state compliance of the file containing all Bed someone from the facility had called her and Hold Policy and Consent Agreement mentioned the bed hold to her when the resident Forms that have been issued. This will be was in the hospital from 5/14/18 through 5/19/18. conducted on a weekly basis for four (4) weeks, then bi-weekly basis for four (4) weeks, then on a monthly basis. On a guarterly basis the Administrator will report the findings and results to the QAA committee for monitoring and recommended changes. THE TITLE OF THE PERSON **RESPONSIBLE FOR IMPLEMENTING** THE ACCEPTABLE PLAN OF CORRECTION. The Administrator is responsible for

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: 6ESN11

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/01/2018 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		345066	B. WING			06/	28/2018
NAME OF PR	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	POOK			4748 OLD SALISBURY ROAD			
ALSTON	SKOOK			L	EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page	e 11	F	625	implementing the acceptable plan of correction.		
F 688 SS=D	Increase/Prevent Dec CFR(s): 483.25(c)(1)-	crease in ROM/Mobility -(3)	F	688			7/26/18
	resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoida §483.25(c)(2) A reside motion receives appro- services to increase re prevent further decreas §483.25(c)(3) A reside receives appropriate assistance to maintai the maximum practica reduction in mobility in This REQUIREMENT by: Based on observation interviews and record utilize left hand and a 35) of 1 residents rev The findings included Resident # 35 was re 06/07/2015 with diago dementia, depression functional quadriplegi	ent with limited range of opriate treatment and range of motion and/or to ase in range of motion. ent with limited mobility services, equipment, and n or improve mobility with able independence unless a s demonstrably unavoidable. T is not met as evidenced ins, staff and resident d review, the facility failed to itm splint for 1 (Resident # iewed for contracture. cl: admitted to the facility on noses that included vascular			THE PLAN OF CORRECTING THE SPECIFIC DEFICIENCY. THE PLAN SHOULD ADDRESS THE PROCESSE THAT LEAD TO THE DEFICIENCY CITED. The processes that lead to the deficien was a result of the facility not having a check system in place to follow through with ensuring that splints/braces are applied consistently and accurately. Th facility has implemented a triple check system to the Functional Maintenance Program. The Staff Development	icy n ie	

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PRINTED: 08/01/2018 FORM APPROVED

		MEDICAID SERVICES				D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		E SURVEY PLETED
		345066	B. WING		06	/28/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
ALSTON E	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 688	Continued From page	a 12	E 68	38		
F 688	was cognitively impair to total assist with act and Resident # 35 wa had functional limitati to both upper and low received occupational 150 minutes for 5 day A review of the care p revealed a care plan Resident # 35 receive passive range of mot extremity (LUE) to ma motion (ROM) and to contracture developm of the splint and that left-hand splint and e hours. The care plan would tolerate the PR no signs or symptoms evidenced by weekly next review. Intervent splint program at leas hours a day, monitor before and after splin assessment quarterly services of any chang included to monitor a of progress in program 35 for program partic	realed that Resident # 35 ired and required extensive tivities of daily living (ADLs) as wheel chair bound and on in range of motion (ROM) ver extremities and had al therapy (OT) services for ys. blans for Resident # 35 initiated on 05/03/2018 that ed restorative therapy for ion (PROM) to the left upper aintain current range of	F 68	<ul> <li>Coordinator will in-servi Nursing Assistants and 2018 on the policy and I Splint training, application documentation to ensur- checked for proper place documentation and hen incorporated into the Net Program for Certified Net and Nurses. In addition re-titled the Restorative Assistant to the title of F Maintenance Certified N The facility has also upor Functional Maintenance included places for staff and a line for the date in splint will begin being af In addition Resident # 3 reevaluated and picked Therapy. Initial Occupate evaluation indicated the change in her range of I wear her splint. Occupate have completed all re-tr no later than July 26th, The procedure for implet follows:</li> <li>As per facility Medi Rehab Director Splint and applications are done M Friday first shift (7am to The Certified Nursing Astantic Nursing Astantic</li> </ul>	Nurses by July 26, procedure for on and e each splint is ement and proper ceforth will be ew Hire Orientation ursing Assistants the facility has Certified Nursing Functional Aursing Assistant. dated the e Plan Form to f members to sign ndicating when the pplying. 5 has been by Occupational tional Therapy are had been no motion or ability to titonal Therapy will raining of care staff 2018. ementation is as cal Director and nd brace londay through 3:30pm) only.	
	A physician (MD) ord revealed that Resider	nt # 35 was to have OT		to the resident is respor placement of splint/brac documentation.	nsible for be and	
	evaluate and treat as Review of an OT orde			2. The Functional Mai Nursing Assistant will be ensure that the splint ha	e responsible to	

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#### 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 688 Continued From page 13 F 688 revealed that Resident # 35 was placed on OT ordered and that documentation is caseload for a left arm splint on 05/17/2018 for 4 completed accurately. The Functional weeks that included therapeutic exercises, Maintenance Certified Nursing Assistant therapeutic activities and orthotic management. will sign behind the residents assigned Certified Nursing Assistant on the An OT note dated 06/24/2018 at 11:08 AM splint/brace/prosthetics rehab revealed that the OT educated the Nurse # 5 documentation form located in the (Nurse) and Nurse Assistant # 1 (NA) on Functional Maintenance Plan notebook on application of the left arm splint. each unit signifying that he/she has checked splint application and On 06/25/2018 at 11:14 AM an observation and documentation. interview conducted with Resident # 35 revealed 3. The nurse assigned to the resident is that Resident # 35 had no left arm splint on her responsible to be the third check which left hand or arm and Resident # 35 revealed that completes the triple check process to she did have a splint to wear on her left arm and ensure the splint has been applied as that she remembered that she always wore it at ordered and that documentation is bedtime. No splint was observed in Resident # completed accurately. 35's room. 4. In the absence of the Functional Maintenance Certified Nursing Assistant a A nurse progress note dated 06/26/2018 at 10:21 designated Administrative Certified AM revealed that Resident # 35 completed the Nursing Assistant or the Clinical Services OT program and would begin the nurse splint Supervisor will serve as a backup. program 5 days a week. 5. The Functional Maintenance Certified Nursing Assistant will be responsible to A review on 06/27/2018 at 4:01 PM of the form give the Functional Maintenance Plan titled Splint/ Brace/Prosthesis Rehab notebook to the nurse for final review and Documentation dated 06/01/2018 through initialing. 06/27/2018 for Resident # 35 revealed that THE PROCEDURE FOR Resident # 35 had received range of motion IMPLEMENTING THE ACCEPTABLE PLAN OF CORRECTION FOR THE (ROM), extension and flexion of the left arm every Monday through Friday and that NA #1 had SPECIFIC DEFICIENCY CITED. applied the new left arm splint on the Resident on The facility has implemented a triple 06/25/2018 through 06/27/2018. check system to the Functional Maintenance Program. The Staff An interview conducted with the Director Nurses Development Coordinator will in-service (DON) on 06/27/2018 at 4:05 PM revealed that the Certified Nursing Assistants and Resident # 35's splint use was documented Nurses by July 26, 2018 on the policy and Monday through Friday in a yellow notebook at procedure for Splint training, application the nurse station. The DON revealed that each and documentation to ensure each splint

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					OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		345066	B. WING		06/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC
F 688	Continued From page	e 14	F 68	3	
F 000	month a licensed nur and that the facility of splints during the day The DON also reveal required for splint app the splint order from the scheduled the splint portion ordered a different so An interview conduct 06/27/2018 at 4:30 Portion ordered a left arm sp 05/29/2018 and that caseload until 06/25/ #1 were educated on that Resident # 35 st program of the left ar stated that she had et 06/19/2018 and NA # functional maintenan provided a form titled Program dated 06/25 Resident # 35's current provide Passive Range slow stretch to impro- and was wearing left daily with no signs or breakdown. The goal would receive PROM upper arm to facilitate application and that Fi left arm splint for 3 to management. The pr 5 days a week and has and NA #1 on the dati in the interview. The only educated the data	se signed the splint forms nly applied and removed v Monday through Friday. ed that MD orders were not oblication as the OT received the MD and the OT also orograms unless the MD chedule. ed with the OT on M revealed that the OT had lint for Resident # 35 on Resident # 35 was on OT 2018 after Nurse # 5 and NA splint use. The OT revealed arted a nursing splint m 06/25/2018. The OT ducated Nurse #5 on 1 on 06/21/2018 on a nurse ce program. The OT Functional Maintenance //2018 that included that ent functional status was to ge of Motion (PROM) and we ROM and joint mobility elbow air splint up to 4 hours		<ul> <li>is checked for proper placement ar proper documentation and hencefor training will be incorporated into the Hire Orientation Program for Certifi Nursing Assistants and Nurses. In addition the facility has re-titled the Restorative Certified Nursing Assis the title of Functional Maintenance Certified Nursing Assistant. The face has also updated the Functional Maintenance Plan Form to included places for staff members to sign ar line for the date indicating when the will begin being applying. In addition Resident # 35 has been reevaluated and picked by Occupa Therapy. Initial Occupational Thera evaluation indicated there had been change in her range of motion or al wear her splint. Occupational Thera have completed all re-training of ca no later than July 26th, 2018. The procedure for implementation in follows:</li> <li>1. As per facility Medical Director Rehab Director Splint and brace applications are done Monday thro Friday first shift (7am to 3:30pm) of The Certified Nursing Assistant assis to the resident is responsible for placement of splint/brace and documentation.</li> <li>2. The Functional Maintenance O Nursing Assistant will be responsible ensure that the splint has been app ordered and that documentation is completed accurately. The Function Maintenance Certified Nursing Assistant assist on the certified Nursing Assistant app ordered and that documentation is completed accurately. The Function</li> </ul>	orth this e New ied tant to cility d d a e splint tional apy n no bility to apy will are staff is as r and ugh nly. signed Certified le to blied as ponal

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#### 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 688 Continued From page 15 F 688 Nursing Assistant on the On 06/28/2018 at 7:40 AM Resident # 35 was splint/brace/prosthetics rehab observed eating in the dining room with no left documentation form located in the hand or arm splint in place. Functional Maintenance Plan notebook on each unit signifying that he/she has On 06/28/2018 at 7:40 AM an interview checked splint application and conducted with NA #1 revealed that she planned documentation. to put the new left arm splint on Resident # 35 3. The nurse assigned to the resident is after breakfast and that the left arm splint was responsible to be the third check which worn during the week (Monday through Friday) completes the triple check process to for about 3 to 6 hours. NA #1 revealed that she ensure the splint has been applied as had been educated about Resident # 35's left ordered and that documentation is arm splint by the OT and that she had been completed accurately. instructed to apply the left arm splint every 4. In the absence of the Functional Monday thru Friday for 3 to 6 hours a day.NA #1 Maintenance Certified Nursing Assistant a stated that she had not applied the splint on the designated Administrative Certified left arm of Resident # 35 as she had taught Nursing Assistant or the Clinical Services beginning on 06/25/2018 through 06/27/2018 and Supervisor will serve as a backup. that she had no reason why the splint had not 5. The Functional Maintenance Certified been used beginning 06/25/2018. Nursing Assistant will be responsible to give the Functional Maintenance Plan On 06/28/2018 at 8:04 AM an interview was notebook to the nurse for final review and conducted with the Assistant Rehab Director initialing. (ARD) that revealed that the OT was responsible THE MONITORING PROCEDURE TO to train at least 1day shift nurse and 1day shift NA ENSURE THAT THE PLAN OF of splint use, would also write the plan of care for CORRECTION IS EFFECTIVE AND the splint program and then it was the nurse staff THAT THE SPECIFIC DEFICIENCY responsibility to follow the plan of care. The ARD CITED REMAINS CORRECTED AND/OR revealed that she would discuss the splint IN COMPLIANCE WITH THE program with the DON because she had not been **REGULATORY REQUIREMENTS:** aware that the facility had ever had a concern The Director of Nursing or Nurse Manager about the splint program before. will be responsible to complete a Quality Assurance Round of the splint application On 06/28/2018 at 11:25 AM an interview with and documentation accuracy on a weekly Nurse # 5 revealed that she was not certain that basis for twelve (12) weeks, then Resident # 35 had the left air splint on for the bi-weekly basis for eight (8) weeks, then dates of 06/25/2018 through 06/27/2018 because on a monthly basis. If at any time it is Nurse #5 stated she had been busy and had not noted that the policy and procedure is not paid attention if the splint had been placed or not. being followed it will be reported to the

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## 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 688 Continued From page 16 F 688 Nurse #5 revealed that Nurse # 5 had been Director of Nursing if she is not educated by the OT about the left arm splint and completing the Quality Assurance check the OT orders for splint application and that she and the Director of Nursing will be had every confidence that NA #5 would apply the responsible to ensure that the retraining is left arm splint. Nurse # 5 revealed that it was the completed. NA's responsibility to report any changes in splint The Director of Nursing will be application to a licensed nurse. responsible to review the reports and take necessary steps to include re-training up An interview conducted with the DON on to include disciplinary action. 06/28/2018 at 7:22 PM revealed that the DON THE TITLE OF THE PERSON **RESPONSIBLE FOR IMPLEMENTING** expected that all splints be applied as ordered and documented on the plan of care as directed THE ACCEPTABLE PLAN OF by the rehab therapist and that she expected all CORRECTION: nurse staff to review the plan of care or ask other The Director of Nursing will be staff if there were any questions or concerns responsible for implementing the related to splint application. acceptable plan of correction as follows. The Nurse Manager will conduct an audit on the Splint application and documentation as stated for the Quality Assurance process. The Director of Nursing will review the report prepared by the Nurse Manager and will be responsible to take necessary steps to include retraining up to include disciplinary action The Quality Assurance forms will be presented to the Quality Assurance Committee on a quarterly basis. F 761 F 761 Label/Store Drugs and Biologicals 7/26/18 SS=D CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 08/01/2018 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345066	B. WING		06	/28/2018
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
	DOOK		4	748 OLD SALISBURY ROAD		
ALSTON E	RUUK		L	EXINGTON, NC 27295		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 761	Continued From page	: 17	F 761			
	§483.45(h) Storage of	f Drugs and Biologicals				
	Federal laws, the facil biologicals in locked of	rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.				
	locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 ar abuse, except when the package drug distribut quantity stored is mini- be readily detected. This REQUIREMENT by: Based on observation	cility must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced		THE PLAN OF CORRECTING		
	-	re expired medications from a rooms and one of three ected for medication		SPECIFIC DEFICIENCY. THE F SHOULD ADDRESS THE PROU THAT LEAD TO THE DEFICIEN CITED. The processes that lead to the c	CESSES ICY	
	pharmacy titled "Shor revealed multi-dose in expired 28 days after An observation was c PM of the 100 Hall me	onducted on 6/26/18 at 1:54 edication room. An		was a result of the facility not fol consistent process of checking t medication carts and refrigerato expired medications. The facility collaborated with the pharmacy sticker for medications that has place to document the expiration We have implemented a proces broadens the scope of the indivi	the rs for / has to obtain a a specific n date. s that duals	
	revealed a multi-dose pen dated with an ope	dication storage refrigerator insulin glargine injection en date of 5/21/18. The ad a sticker label on it which		responsible for checking for exp medications. We have also set a for which the carts and refrigera be checked. The Staff Developm	a schedule tors are to	

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#### 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 761 Continued From page 18 F 761 stated to discard the insulin injection pen 28 days Coordinator will in-service the nurses by after opening. The insulin injection was stored July 26, 2018 concerning the policy and inside of a container which also had been dated procedure for labeling, dating and as opened on 5/21/18 and had a sticker label that destroying medications to include stated to discard the insulin injection pen 28 days medications that are in single dose after opening. Nurse #2 who was present during administration forms, in the appropriate the observation and whose cart the medication time frame. In addition this training has was discovered on stated the medication should been incorporated into the new nurse have been discarded due to the insulin injection employee orientation training program. pen having been opened more than 28 days ago. The procedure will be as follows: 1. When a medication (such as eye An interview was conducted with the Director of drops, insulin, inhalers) that have a shelf Nursing (DON) on 6/28/18 at 7:00 PM. The DON life that requires an expiration date once stated her expectation was for expired insulin to opened by the nurse, is sent by the be disposed of. pharmacy it will now contain a sticker with a place for an opening date, an expiration 2. An observation was conducted on 6/26/18 at date and the nurses initials. 2:07 PM of cart #3 which was used for the 300 2. When a medication (such as eve Hall of the facility. An observation discovered a drops, insulin, inhalers) is opened by the multi-dose insulin lispro injection pen dated with nurse it will be his/her responsibility to an open date of 5/27/18. Nurse #3 who had been label the bottle/package/pen with the open assigned to cart #3 stated she usually disposed date and the expiration date along with of the insulin lispro injection pen on day 30. their initials. Nurse #3 contacted the facility's pharmacy and 3. A Medication Reference Guide is obtained a document titled "Short Dated placed in the narcotic notebooks on each Medications 2012." Review of the document cart that have specific time frames for revealed the multi-dose insulin lispro injection pen usage. Based upon this information the expired 28 days after the pen was opened. The nurse will calculate the number of days in nurse stated she was going to dispose of the order to list the expiration date of the multi-dose insulin injection pen due to it having medication. been opened more than 28 days ago. Each nurse is responsible when 4 administering medications to note if the An interview was conducted with the Director of medication has been labeled with an open Nursing (DON) on 6/28/18 at 7:00 PM. The DON date. If it is not labeled the medication will stated her expectation was for expired insulin to be dated based upon the fill date of the be disposed of. medication on the label. 5. Each nurse is responsible to review the cart during their 8/12 hour shift for expired medications. The nurse will sign

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TATEMENT	OF DEFICIENCIES	X MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		345066	B. WING		06/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COMPLETIO
F 761	Continued From par	ge 19	F 76	1 a form at the end of the shift tha located in the narcotic count boo they have reviewed the cart and medications were removed. 6. Expired medications will be from each cart and will be place tote to send back to the pharma destroyed on the next scheduled date. 7. The Nurse on the 11pm-7ar be responsible to check the medications to include refrigerated medications are labeled and tha medications are labeled and tha medications that are discontinue out of date will be placed in the fisch send back to pharmacy to be dee on the next scheduled pick up d THE PROCEDURE FOR IMPLEMENTING THE ACCEPT. PLAN OF CORRECTION FOR SPECIFIC DEFICIENCY SITED The Staff Development Coordina in-service the nurses by July 26, concerning the policy and proce labeling, dating and destroying medications to include medication (such a drops, insulin, inhalers) that hav life that requires an expiration date opened by the nurse, is sent by pharmacy it will now contain a si a place for an opening date, an date and the nurses initials.	bk that         expired         removed         d in the         cy to be         d pick up         m shift will         dication         edications         cations         on Room         hose         t all         ed or are         tote to         stroyed         ate.         ABLE         THE         :         ator will         2018         dure for         ons that         o forms, in         :         as eye         e a shelf         ate once         the         ticker with

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	S FOR MEDICARE 8	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		<u> </u>	COMPLETED
		345066	B. WING		06/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 761	Continued From page	ge 20	F 76	<ol> <li>When a medication (s drops, insulin, inhalers) is of nurse it will be his/her resp label the bottle/package/ped date and the expiration date their initials.</li> <li>A Medication Reference placed in the narcotic note cart that have specific time usage. Based upon this in nurse will calculate the nur order to list the expiration of medication.</li> <li>Each nurse is respons administering medications medication has been labeled date. If it is not labeled the be dated based upon the fill medication on the label.</li> <li>Each nurse is respons the cart during their 8/12 h expired medications. The a form at the end of the sh located in the narcotic count they have reviewed the can medications were removed 6. Expired medications w from each cart and will be tote to send back to the ph destroyed on the next sche date.</li> <li>The Nurse on the 11pp be responsible to check the rooms to include refrigerate on each unit and the stock located in Lillian's Way Me on a bi-weekly basis to ens medications that are disconting medications that are disconting</li></ol>	ppened by the onsibility to en with the open e along with ce Guide is books on each frames for formation the nber of days in date of the bible when to note if the ed with an open e medication will II date of the bible to review our shift for nurse will sign ift that will be nt book that t and expired L. vill be removed placed in the armacy to be eduled pick up m-7am shift will e medications medications dication Room sure those ind that all

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		345066	B. WING		06/28/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE
F 761	Continued From pag	je 21	F 76	out of date will be placed send back to pharmacy to on the next scheduled pion THE MONITORING PRO ENSURE THAT THE PLA CORRECTION IS EFFECT THAT THE SPECIFIC DE CITED REMAINS CORRET IN COMPLIANCE WITH T REGULATORY REQUIRET The Director of Nursing of will be responsible to com Assurance Round of Med and Rooms on a weekly be weeks, then bi-weekly be month, then on a monthly Medication Carts and Roo monitored to ensure that the dating and returning medi protocol. If at any time it it policy and procedure is no it will be reported to the D Nursing if she is not comp Quality Assurance check of Nursing will be response that the retraining is comp The Director of Nursing w responsible to review the necessary steps to includ to include disciplinary acti THE TITLE OF THE PER RESPONSIBLE FOR IMF THE ACCEPTABLE PLAN CORRECTION: The Pharmacy Representative/Pharmaci comes to the facility on a and while here conducts a medication carts and the	be destroyed k up date. CEDURE TO N OF CTIVE AND FICIENCY ECTED AND/OR THE EMENTS: r Nurse Manager oplete a Quality ication Carts basis for eight (8) sis for one (1) basis. The basis. The basis for one (1) basis for one (1) basis. The basis or eight (8) sis for one (1) basis as per is noted that the ot being followed irrector of bleting the and the Director sible to ensure bleted. ill be reports and take e re-training up ion. SON PLEMENTING N OF st Consultant monthly basis an audit of

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	PLETED
		345066	B. WING		06/28/2018	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON	BROOK			748 OLD SALISBURY ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 761	Continued From page	e 22	F 761	Rooms. In their report to the Direct Nursing they will list the deficient put that were noted. The Director of Nursing will be responsible to review the report and necessary steps to include re-traini to include disciplinary action. The Quality Assurance forms will be presented to the Quality Assurance committee on a quarterly basis.	ractices d take ng up e	
F 842 SS=D	§483.20(f)(5) Residen (i) A facility may not r resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co agrees not to use or of except to the extent to to do so. §483.70(i) Medical re-	483.70(i)(1)-(5) nt-identifiable information. elease information that is o the public. elease information that is o an agent only in intract under which the agent disclose the information he facility itself is permitted	F 842			7/26/18
	professional standard must maintain medica that are- (i) Complete; (ii) Accurately docum (iii) Readily accessibl (iv) Systematically or §483.70(i)(2) The fac all information contain	ds and practices, the facility al records on each resident ented; e; and ganized ility must keep confidential ned in the resident's records, n or storage method of the n release is-				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/01/2018 MAPPROVED D. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì, í		LE CONSTRUCTION	(X3) DATE	
		345066	B. WING			06/	28/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506 (iv) For public health a neglect, or domestic v activities, judicial and law enforcement purp purposes, research p medical examiners, fu a serious threat to heal by and in compliance §483.70(i)(3) The faci- record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requireme (iii) For a minor, 3 year legal age under State §483.70(i)(5) The mer (i) Sufficient information (ii) A record of the ress (iii) The comprehension provided; (iv) The results of any and resident review e determinations condur (v) Physician's, nurse professional's progress (vi) Laboratory, radiol	permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. ility must safeguard medical ainst loss, destruction, or required by State law; or e date of discharge when ent in State law; or ars after a resident reaches e law. dical record must contain- on to identify the resident; sident's assessments; ve plan of care and services y preadmission screening evaluations and icted by the State; i's, and other licensed	F	842	2		

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#### 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 842 Continued From page 24 F 842 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff THE PLAN OF CORRECTING THE and resident interviews, the facility failed to SPECIFIC DEFICIENCY. THE PLAN accurately document the left elbow air splint for SHOULD ADDRESS THE PROCESSES one of one residents (Resident # 35) reviewed for THAT LEAD TO THE DEFICIENCY splint documentation. CITED. The findings included: The processes that lead to the deficiency was a result of the facility not having a Resident # 35 was readmitted to the facility on check system in place to monitor the accuracy of the documentation in relation 06/07/2015 with diagnoses that included vascular dementia, depression, abnormal posture, to splint application. Resident # 35 has functional quadriplegia and left elbow contracture. been reevaluated and picked by Occupational Therapy. Initial Occupational A review of a quarterly Minimum Data Set (MDS) Therapy evaluation indicated there had dated 04/19/2018 revealed that Resident # 35 been no change in her range of motion or was cognitively impaired and required extensive ability to wear her splint. Occupational to total assist with activities of daily living (ADLs) Therapy will have completed all re-training and Resident # 35 was wheel chair bound and of care staff to include proper had functional limitation in range of motion (ROM) documentation no later than July 26th. to both upper and lower extremities and had 2018. received occupational therapy (OT) services for The facility has developed a triple check system to ensure that the appropriate 150 minutes for 5 days. documentation performed by the Certified A review of the care plans for Resident #35 Nursing Assistant is done accurately. All revealed a care plan initiated on 05/03/2018 that documentation will be checked and Resident # 35 received restorative therapy for signed behind for accuracy by the passive range of motion (PROM) to the left upper Functional Maintenance Certified Nursing extremity (LUE) to maintain current range of Assistant and the nurse assigned to and motion (ROM) and to reduce the risk of responsible for the resident will be contracture development and ease of application responsible for signing behind the of the splint and that Resident # 35 was to wear a Certified Nursing Assistant and Functional left-hand and elbow air splint for up to six hours. Maintenance Certified Nursing Assistant The care plan goal was that Resident # 35 would attesting to the accuracy of the tolerate the PROM and splint program with no documentation. The Staff Development signs or symptoms of skin breakdown as Coordinator will in-service the Certified evidenced by weekly skin checks through the Nursing Assistants and Nurses by July 26, next review. Interventions included to provide 2018 on the policy and procedure for splint program at least 5 days a week for 3 to 6 proper documentation. Henceforth this

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#### 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 842 Continued From page 25 F 842 hours a day, monitor skin for pressure or redness training will be incorporated into the New before and after splint worn, monitor contracture Hire Orientation Program for Certified assessment guarterly and to notify therapy Nursing Assistants and Nurses. services of any changes. Interventions also The procedure is as follows: included to monitor and document Resident #35 The Functional Maintenance Certified 1. of progress in program and to praise Resident# Nursing Assistant will be responsible to 35 for program participation to give cues as ensure that documentation is completed needed and to provide PROM exercises as accurately. The Functional Maintenance directed by the OT. Certified Nursing Assistant will sign behind the residents assigned Certified Nursing An MD order dated 05/29/2018 revealed that a Assistant on the splint documentation left elbow orthosis had been ordered for Resident form located in the Functional # 35. Maintenance Plan notebook on each unit signifying that he/she has checked On 06/25/2018 at 11:14 AM an observation and documentation. interview conducted with Resident # 35 revealed 2. The resident's assigned nurse is that Resident # 35 had no left arm air splint on responsible to be the third check which her left hand or arm and Resident # 35 revealed completes the triple check process to that she did have a splint to wear on her left arm ensure that documentation is completed and that she remembered that she always wore it accurately. at bedtime. No splint was observed in Resident # In the absence of the Functional 35's room. Maintenance Certified Nursing Assistant a designated Administrative Certified An interview conducted with the Director Nurses Nursing Assistant, the Clinical Services (DON) on 06/27/2018 at 4:05 PM revealed that Supervisor will serve as a backup. Resident # 35's left arm air splint use was THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE documented Monday through Friday in a yellow notebook at the nurse station. The DON revealed PLAN OF CORRECTION FOR THE that each month a licensed nurse signed the SPECIFIC DEFICIENCY CITED. splint forms and that the facility only applied and Resident # 35 has been reevaluated and removed splints during the day Monday through picked by Occupational Therapy. Initial Friday. The DON also revealed that MD orders Occupational Therapy evaluation were not required for splint application as the OT indicated there had been no change in her received the splint order from the MD and the OT range of motion or ability to wear her also scheduled the splint programs unless the splint. Occupational Therapy will have MD ordered a different schedule. completed all re-training of care staff to include proper documentation no later A review of the yellow splint book with the DON than July 26th, 2018. on 06/27/2018 at 4:05 PM revealed a form titled The facility has developed a triple check

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345066		(X2) MULTIPL	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:	A. BUILDING	06/28/2018		
		B. WING				
NAME OF PROVIDER OR SUPPLIER						STREET ADDRESS, CITY, STATE, ZIP CODE
ALSTON E	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COM	(X5) MPLETIC DATE
F 842			F 842	responsible to ensure that the retrain completed. The Director of Nursing will be responsible to review the reports and necessary steps to include re-training to include disciplinary action. THE TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE ACCEPTABLE FLAN OF CORRECTION: The Director of Nursing will be responsible for implementing the acceptable plan of correction as follow The Nurse Manager will conduct and on the Splint application and documentation as stated for the Qua Assurance process. The Director of Nursing will review the report prepare the Nurse Manager and will be responsible to take necessary steps include retraining up to include disci- action. The Quality Assurance forms will be presented to the QA Committee on a	ng is take up G ws. udit ity d by o	
F 880 SS=D	Infection Prevention a CFR(s): 483.80(a)(1)		F 880	quarterly basis.	7/26	6/18
	infection prevention a designed to provide a comfortable environm development and tran diseases and infection	blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 08/01/2018 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345066	B. WING			06/	28/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALSTON E	BROOK				4748 OLD SALISBURY ROAD LEXINGTON, NC 27295		
(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 880	The facility must estal and control program ( a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whor communicable diseas reported; (iii) Standard and tran to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement tha least restrictive possible circumstances. (v) The circumstances must prohibit employed disease or infected sk	blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, ig, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; e standards, policies, and ogram, which must include, llance designed to identify ble diseases or can spread to other ; m possible incidents of se or infections should be insmission-based precautions rent spread of infections; olation should be used for a t not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the s under which the facility ees with a communicable kin lesions from direct s or their food, if direct	F	880			

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# 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) 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 880 Continued From page 29 F 880 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: THE PLAN OF CORRECTING THE Based on observations, record review, and staff interviews the facility failed to follow contact SPECIFIC DEFICIENCY. THE PLAN precautions for one of one resident reviewed for SHOULD ADDRESS THE PROCESSES THAT LEAD TO THE DEFICIENCY pressure ulcers (Resident #68). CITED. Findings included: The processes that lead to the deficiency were a result of the facility not having a A review of the facility policy titled Contact procedure in place to adequately train the Isolation & Standard Precautions, revealed the treatment nurse. The facility has following: implemented a system that will more -Standard precautions will be used in the care of specifically address the policy and all residents regardless of their diagnosis or procedure during training. The Director of presumed infections status. Nursing completed Counseling and Re-education of the treatment nurse on A review of the Contact Precautions posting July 4th, 2018. Re-education included revealed the following: reviewing the Alston Brook Clean -Wear gloves when entering room or cubicle, and Dressing Change Policy and review of when touching patient's intact skin surfaces, or Wound Source publication on Clean articles in close proximity. Dressing Techniques, including a "cheat sheet" for dressing changes with clean A review of the medical record revealed Resident technique. #68 was originally admitted to the facility on The Staff Development Coordinator will

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 880 Continued From page 30 F 880 5/12/18 and was readmitted to the facility on complete a re-training by July 26th, 2018 5/19/18. with the Monday through Friday Treatment Nurse and the Weekend Treatment Nurse Review of Resident #68's electronic medical to include the following: record revealed the resident was on contact 1. Importance of Infection Control in precautions for a Urinary Tract Infection (UTI) relation to wounds where the infectious bacteria was documented as 2. Preparing a clean vs. sterile field Methicillin-Resistant Staphylococcus Aureus 3 Proper cleaning of equipment utilized (MRSA). Further review revealed the resident during treatment. had a pressure ulcer to the left heel for which he 4. Isolation Precautions in Relation to was receiving dressing changes. Review of the Wounds physicians' Medication Administration Record A skills check off will be completed by the (MAR) revealed the resident received the Staff Development Coordinator with the following antibiotics for the treatment of the UTI: Treatment Nurses prior to July 25th, 2018. Sulfamethoxazole DS one tablet orally each day If the Treatment Nurses does not attend from 6/5/18 through 6/6/18, Sulfamethoxazole DS the re-training and complete the Skills one table twice daily orally from 6/7/18 through Check off by the specified date she will 6/12/18, and tetracycline 250 milligram (mg) one not be allowed to work until completed. tablet twice daily orally from 6/13/16 through THE PROCEDURE FOR IMPLEMENTING THE ACCEPTABLE 6/19/18. PLAN OF CORRECTION FOR THE A continuous observation of a dressing change to SPECIFIC DEFICIENCY SITED: the residents left foot completed by Nurse #4 for The Director of Nursing completed Resident #68 was conducted on 6/27/18 at 10:05 Counseling and Re-education of the AM. There was signage outside of the Resident treatment nurse on July 4th, 2018. #68's room for notification of the room being Re-education included reviewing the under Contact Precautions. The notification for Alston Brook Clean Dressing Change Contact Precautions included: Wear gloves when Policy and review of Wound Source entering room or cubicle, and when touching publication on Clean Dressing patient's intact skin surfaces, or articles in close Techniques, including a "cheat sheet" for proximity. Resident #68 was resting in bed and dressing changes with clean technique. was in a contact precautions room. The The Staff Development Coordinator 1. observation of the dressing change included the will complete a re-training by July 26th, following breaches of infection control: 2018 with the Monday through Friday -The barehanded nurse proceeded apply the Treatment Nurse and the Weekend resident's sock, covered the resident's foot with a Treatment Nurse to include the following: sheet and comforter, and proceeded to lower the 2. Importance of Infection Control in resident's bed from the working level it had been relation to wounds 3. Preparing a clean vs. sterile field at.

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#### 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 345066 B. WING 06/28/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4748 OLD SALISBURY ROAD ALSTON BROOK LEXINGTON, NC 27295 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 880 Continued From page 31 F 880 -After washing her hands the nurse picked up the 4. Proper cleaning of equipment utilized bandage scissors and pen from the resident's during treatment. over the bed table and proceeded to exit the Isolation Precautions in Relation to 5. contact precautions room without having had Wounds cleaned the bandage scissors or the pen. As the A skills check off will be completed by the nurse was taking the biohazard bag to the soiled Staff Development Coordinator with the utility room, she placed the bandage scissors and Treatment Nurses prior to July 26th, 2018. the pen directly on the wound/treatment cart If the Treatment Nurses does not attend which was located in the hall outside of the the re-training and complete the Skills resident's room. The nurse then proceeded to go Check off by the specified date she will not be allowed to work until completed. to the soiled utility room to dispose of the biohazard bag and then to the clean utility room THE MONITORING PROCEDURE TO where she washed her hands. The nurse then ENSURE THAT THE PLAN OF returned to the wound treatment cart and CORRECTION IS EFFECTIVE AND proceeded to clean the bandage scissors and the THAT THE SPECIFIC DEFICIENCY pen with a disinfectant wipe. CITED REMAINS CORRECTED AND/OR IN COMPLIANCE WITH THE An interview was conducted with Nurse #4 on **REGULATORY REQUIREMENTS:** 6/27/18 at 11:12 AM. The nurse stated she did Any new Treatment Nurse will be 1. not have three pairs of gloves and after she had trained by the Staff Development removed her gloves after applying the dressing Coordinator on the following during their she should have put on another pair of gloves orientation or prior to assuming the when she applied the resident's sock. The nurse Treatment Role: stated she did not see her placing the scissors on a. Importance of Infection Control in her cart as an opportunity for the spread of relation to wounds Preparing a clean vs. sterile field infection because she used an antiseptic wipe to b. clean the scissors and the surface of her Proper cleaning of equipment utilized C. wound/treatment cart after she had placed the during treatment. scissors on her cart. d. Isolation Precautions in Relation to Wounds An interview was conducted with the Director of The Director of Nursing or Designee 2 Nursing (DON) on 6/27/18 at 3:40 PM. The DON will Monitor treatments to ensure Infection stated the nurse should have used a disinfectant Control procedures are being practiced as wipe on the scissors before she left the room. follows: а Monitor two (2) treatments per week for four (4) weeks; then b. Monitor one (1) treatment per week for four (4) weeks; then Monitor one (1) treatment monthly C.

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345066		(X2) MULTIP A. BUILDING	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		B. WING		06/28/2018	
			STREET ADDRESS, CITY, STATE,	ZIP CODE	
ALSTON	BROOK			4748 OLD SALISBURY ROAD LEXINGTON, NC 27295	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE COMPLETIO TO THE APPROPRIATE DATE CIENCY)
F 880	Continued From pag	je 32	F 88	<ul> <li>until resolved by the Qu Committee.</li> <li>d. The Director of Nu will monitor one (1) treat each month going forwards. The Director of Nu report prepared by the be responsible to take to include retraining up to action.</li> <li>4. The Quality Assurat presented to the Quality Committee on a quarte THE TITLE OF THE PE RESPONSIBLE FOR II THE ACCEPTABLE PL CORRECTION: The Director of Nursing report and take necesss include re-training up to disciplinary action. The Quality Assurance presented to the Quality Committee on a quarte</li> </ul>	rsing or Designee atment periodically ard. rsing will review the Designee and will necessary steps to include disciplinary ance forms will be y Assurance rly basis. ERSON MPLEMENTING AN OF g will review the ary steps to o include forms will be y Assurance

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