STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 6/25/19 through 6/28/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #VYUW11.	E 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		7/19/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/22/2019

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F 585	Continued From page 1	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, Resident Council members interview and staff interviews, the facility failed to ensure residents and/or representatives had the right to file grievances anonymously. Findings included: A review of the grievance procedure posted on the wall in the hallway of the front entrance of the facility revealed, "Residents or resident representatives have the right to file grievances verbally or in writing. Grievances can also be filed anonymously."	F 585	The Director of Nursing, Social Worker, and Administrator, updated the current grievance policy and grievance forms. The following was updated: where residents and/or their representatives can locate a grievance/complaint form, and where an anonymous grievance/complaint form can be filed. All residents and/or their representatives will be educated on the updated grievance policy and forms by 8/15/19. This will be achieved by adding it to the monthly newsletter, resident council, the admission packet, and the family bulletin	

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F 585	Continued From page 3 During the Resident Council meeting on 6/27/19 at 1:15 PM, the members of the Resident Council stated they were unaware how a grievance was filed and had no knowledge of how a grievance form was obtained. On 6/27/19 at 1:55 PM a tour of the facility revealed no grievance forms were available without asking staff for one to be provided. On 6/27/19 at 2:01 PM an interview was completed with the Activities Director. She said that grievance forms were located in the social work office or on the facility's computer share drive. The Activities Director stated grievance forms were available when a resident or representative requested one from staff members and then it was printed out. On 6/27/19 at 2:29 PM an interview was completed with Social Worker (SW) #1. She stated grievance forms were located in the social worker's office or at the nurse's station. She said the process for filing a grievance included the resident or representative went to either the social worker office or nurse's station and requested a grievance form. Social Worker #1 further stated the facility did not have a process in place for grievances to be filed anonymously. On 6/28/19 at 2:28 PM an interview was completed with Nurse #1. She said grievance forms were located in a file cabinet at the nurse's station. Nurse #1 stated a resident or representative asked staff for a grievance form if they wanted to file a grievance. On 6/28/19 at 1:47 PM an interview was completed with the Administrator. He stated he	F 585	board. All current employees will be educated on the updated grievance policy by 8/15/19 and yearly thereafter. All new hires will be educated during their orientation. The Director of Nursing or her designee will do weekly audits for 4 weeks then monthly thereafter to ensure the new grievance forms are accessible to all residents and resident representatives, with a location to file anonymously. The facility had the new grievance forms and where to file anonymously completed on 7/19/19. Procedures will be assessed and reviewed at QAPI meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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F 585	Continued From page 4 was unaware of the regulation that residents or representatives had the right to have grievances filed anonymously, therefore, grievance forms were not available to residents or representatives without requesting the form from staff members.	F 585		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		7/31/19

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F 655	Continued From page 5 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop baseline care plans that included fall risk interventions for 2 of 4 (Resident #1 & Resident #3) sampled residents reviewed for falls. Findings included: 1)Resident #1 was admitted to the facility on 6/14/19. Diagnoses included in part, pneumonia, chronic obstructive pulmonary disease, encephalopathy, and acute on chronic respiratory failure. Record review revealed that Resident #1 required 1-person extensive assistance for activities of daily living (ADLs), was occasionally confused and impulsive, had a history of falls, and was occasionally incontinent. Review of Resident #1's Baseline Care Plan completed on 6/14/19 revealed that the resident was considered a fall risk but did not list interventions in place to prevent falls.	F 655	The facility immediately updated Resident #1 and #3's baseline care plans to reflect fall precautions and interventions on 6/27/19. The baseline care plan was revised to include additional goals and interventions with an emphasis on fall precautions. All licensed staff were educated on the new baseline care plan by 6/30/19. Education on base line care plans will be completed with all new hire licensed staff in orientation. Audits will be conducted on any resident not having a comprehensive care plan by 7/31/19 to ensure baseline care plans include fall precautions and interventions. All admissions will have their baseline care plan reviewed for appropriate fall interventions weekly for 4 weeks, then monthly for 3 months by the Director of Nursing or her designee. The facility had the updated baseline care	

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F 655	Continued From page 6 During an interview with the Director of Nursing (DON) on 6/28/19 at 1:32 PM she stated that all resident's in the building were considered fall risks and that their baseline care plan did not address specific interventions due to their universal fall precautions policy that included: bed at lowest position, call bell within reach, and slip-resistant socks/footwear. She stated that the baseline care plan form was something that she wanted to change, so that it was personalized to each resident and that the fall interventions were listed on the care plan. She stated that it was her expectation that all residents were considered a fall risk and that their base line care plans reflected individualized interventions specific to each resident before and after falls take place. 2)Resident #3 was admitted to the facility on 5/29/19. Diagnoses included in part, Parkinson's Disease, seizure disorder, and dementia. Review of Resident #3's minimum data set assessment from 6/5/19 revealed that he was cognitively impaired, incontinent of bladder and bowel, had a history of falls, and required one to two-person extensive assistance with ADLs. Review of Resident #3's Baseline Care Plan completed on 5/29/19 revealed that the resident did not have a care plan in place for fall risk. During an interview with the Director of Nursing (DON) on 6/28/19 at 1:32 PM she stated that all resident's in the building were considered fall risks and that their baseline care plan did not address specific interventions due to their universal fall precautions policy that included: bed at lowest position, call bell within reach, and slip-resistant socks/footwear. She stated that the	F 655	plan completed by 6/30/19. Procedures will be assessed and reviewed at QAPI meetings. Changes to procedures or processes will be implemented immediately if necessary. The Administrator is responsible for overall compliance.	

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F 655	Continued From page 7 baseline care plan form was something that she wanted to change, so that it was personalized to each resident and that the fall interventions were listed on the care plan. She stated that it was her expectation that all residents were considered a fall risk and that their base line care plans reflected individualized interventions specific to each resident before and after falls take place.	F 655		