STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 10/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE HEALTH AND REHABILITATION OF ASHEBORO	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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
F 000	INITIAL COMMENTS On 9/30/19 through 10/1/19 an unannounced complaint survey was conducted. 7 of the 7 allegations were not substantiated. See event ID KDZV11.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review interviews with staff, resident representative, and physician, the facility failed to do neurological checks (neurochecks) after an unwitnessed fall (Resident #1) for 1 of 3 residents reviewed for accidents. Findings included: Resident #1 was admitted to the facility on 8/29/19 with the diagnoses of history of falling at home with resulting left rib fracture that was unable to confirm by x-ray and age-related osteoporosis. The resident had an incident report documented that revealed an unwitnessed fall on 9/4/19 at 10:20 pm. The resident was found lying flat (back) on the floor next to her bed. The resident denied any pain and range of motion of the four extremities were intact. The resident was noted to be confused.	F 684	F684 Quality of Care CRF(s) 483.25 Resident #1 was discharged from the facility on 9/8/19 to the Emergency Department for evaluation and treatment. Resident #1 did not return to the facility after the date of discharge. All incident and accident reports that involved an unwitnessed fall were audited to ensure that neurochecks were initiated and documented 72 hours post fall for the last 30 days dating back from 10/17/19. This was completed by the Director of Nursing and Assistant Director of Nursing on 10/24/19. If the audit revealed additional noncompliance to the standard of 72 hours of neurochecks being completed and documented, the resident	10/29/19

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

Electronically Signed | 10/25/2019

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F 684	Continued From page 1 Staff communication form (SBAR) and progress note dated 9/4/19 at 10:20 pm documented vital signs and resident records reviewed. The resident's primary diagnoses were dementia and weakness. There were medication changes in the past week. Blood pressure was 180/72 and pulse was 106. Oxygen saturation on room air was 92%. Suspected problem that contributed to the fall was left blank. The resident "appeared to by lying on her back on the floor with no complaints of pain and range of motion was completed without complications." The plan was to monitor vital signs. Resident was able to state, "I need the toilet in the bathtub (bathroom)." Resident representative and attending physician were notified at 9/4/19 at 10:20 pm. The form was signed by Nurse #1. A review of the resident's nurses' note for 9/7/19 did not reveal any documentation. On 9/30/19 at 3:30 pm an interview was conducted with Nurse #1 who was assigned to the resident on 9/7/19 and 9/8/19 and was the nurse in charge (weekend). Nurse #1 was not aware that the resident had a fall on 9/4/19. Nurse #1 commented that when there is an unwitnessed fall the resident would be assessed for potential injury after the fall and neuro checks would be done. Nurse #1 would normally assess the resident for 3 days, especially if there was pain or they hit their head. He also commented that this would be documented, and he believed this was the facility standard. Nurse #1 commented that he did not assess the resident for injury post fall while assigned on 9/7/19. On 8/30/19 at 2:40 pm an interview was conducted with Nurse #2 who was assigned to Resident #1 the night she fell on 9/4/19. Nurse #2 stated that the resident was found on the floor	F 684	was assessed, physician contacted, and treated as indicated by the physician. This will be documented on the audit tool. Education was provided to all staff nurses on the standard of 72-hour neurochecks to be completed for all unwitnessed falls. This was conducted by the Staff Development Nurse, Assistant Director of Nursing, and Director of Nursing. This will be completed by 10/25/19. All newly hired nurses will receive this education upon hire. An audit tool was created to ensure compliance to this standard. The Director of Nursing, Assistant Director of Nursing, Staff Development Nurse, and Unit Managers will audit all incident and accident reports to ensure that 72 hours of neurochecks are completed and documented for all unwitnessed falls. This will begin on 10/28/19 and continue 5 X a week as a part of their daily clinical meeting on an ongoing basis. The Director of Nursing will bring to the Quality Assurance and Performance Committee the audits to discuss monthly in the Quality Assurance and Performance Improvement Committee Meeting to determine the effectiveness and duration of the audits.	

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F 684	Continued From page 2 in her room between the bed and the wall. The resident was wet and trying to get to the toilet. The resident denied pain. Range of motion to extremities were within normal limits. There was no obvious injury. Nurse #2 indicated that the resident had dementia and could be confused. The resident was educated to use the call light and added additional supervision on his shift. Nurse #2 stated that he believed the facility expectation for an unwitnessed resident fall would be to assess the resident for injury to include neurological checks. He commented the assessment would include observation for deformity and bruising and new onset of pain. Nurse #2 believed that the timeframe was 3 days and would be documented. There was no evidence that the neurochecks were done for three days after the resident's fall. On 10/1/19 at 8:45 am an interview was conducted with the attending Physician for the Resident #1. The Physician stated he was informed the resident was found lying on the floor in her room and it was believed that the resident had fallen (unwitnessed). The Physician also expected facility staff to assess the resident after her fall for three days and document. The Director of Nursing (DON) was interviewed on 10/1/19 at 11:30 am who stated that she was not aware that nursing did not document post fall assessments for Resident #1 after her fall on 9/4/19 and after her change in assessment of chest pain on 9/5/19 and after. The DON stated that her expectation from staff for a resident unwitnessed fall would be to assess the resident for three days or as ordered and document to include a neurological check.	F 684		
F 804	Nutritive Value/Appear, Palatable/Prefer Temp	F 804		10/29/19

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F 804 SS=B	Continued From page 3 CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on resident interview, observation, record review and staff interview, the facility failed to serve food and coffee at breakfast meals that was palatable and at an appetizing temperature to four of seven sampled residents reviewed for food palatability (Residents #2, #4, #5 and #7). Findings included: 1.Interviews with residents on 9/30/19, revealed four of seven residents interviewed voiced concerns about the temperature of food and coffee they were served at breakfast being too cold. a. Resident #2's Minimum Data Set (MDS) Quarterly Review (QR) completed on 7/10/19 revealed the resident was alert and oriented. Interview with Resident #2 on 9/30/19 at 10:28 AM and revealed she had concerns that the breakfast was usually cold. She said she called the Food Service Account Manager when things were not right with the food. On 10/01/19 at 12:13 PM, she said the breakfast was not hot or cold, the temperature was medium, and the pancakes were a little hard around the edges.	F 804	F804 NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP CFR(s): 483.60(d)(1)(2) The plate warmer was repaired to ensure that meals maintain a preferred and palatable temperature. This was completed by the maintenance staff on 10/2/19. A test tray assessment was conducted by the Dietary Manager to ensure Resident #2, #4, and #7 have a palatable meal at the preferred temperature. Resident #5 discharged on 10/2/19. This was conducted on 10/21/19. An audit, using the Resident Tray Assessment Tool, was conducted to ensure that all residents receive breakfast food and coffee at desired temperatures. This was conducted on 10/24/19 by the Dietary Manager. Education was provided to all dietary staff in regards to utilizing the plate warmer to ensure that all meals are served palatable	

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F 804	Continued From page 4 b. Resident #4's admission MDS completed on 8/15/19 revealed the resident was alert and oriented. Interview with Resident #4 on 09/30/19 at 10:30 AM revealed he occasionally received cool eggs and coffee at breakfast. The resident said he was tired of asking for his food to be reheated. c. Resident #5's admission MDS dated 9/28/19 revealed he was alert and oriented. Interview with Resident #5 on 09/30/19 at 4:10 PM revealed he frequently received cold food at breakfast, and he had not asked for his food to be reheated. d. Resident #7's MDS QR dated 8/16/19 revealed she understood and understands, had clear speech and intact cognition. Interview with Resident #7 on 9/30/19 at 2:30 PM revealed she periodically was served cold eggs and coffee at breakfast. She believed staff were aware of her concern because she had asked for her food to be reheated. On 10/1/19 at 7:30 AM, the kitchen tray line was observed. The breakfast meal service was in progress. Many residents' trays were observed prepared from the kitchen tray line intermittently between 7:30 AM on 8:00 AM on 10/1/19. Observations of staff preparing resident breakfast meals revealed they would obtain a plate from a plate warmer, place food from the tray line onto the plate and then set the plate of food on a resident's breakfast tray. On 10/01/19 at 8:06 AM the kitchen's plate warmer, which was used to heat plates to keep foods served on resident meal trays hotter, was noted not to be turned on and the unit that held the plates was at room	F 804	and at preferred temperatures. This was completed by the Dietary Manager on 10/24/19. An audit will be conducted daily X 5 days a week for 2 weeks, then 3 X a week for 2 weeks, then weekly X 2 weeks using the Resident Tray Assessment audit tool for breakfast meals. This will be completed by the Dietary Manager beginning on 10/21/19 to ensure breakfast meal temperatures are palatable. All audit results will be discussed in the monthly Quality Assurance and Performance Improvement Committee meeting to determine effectiveness and duration of the audit.	

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F 804	Continued From page 5 temperature. Interview with the Food Service Account Manager on 10/1/2019 at 8:06 AM revealed he did not realize the plate warmer had not been turned on. He said he was involved with the Resident Council Group and he had not received a lot of food complaints.	F 804		