	MENT OF HEALTH AN		FORM APPROVED OMB NO. 0938-0391			
CENTER	S FOR MEDICARE &	MEDICAID SERVICES	1			<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345089		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 06/01/2020	
		B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
	COVE HEALTH AND REF			511 WINDMILL STREET		
WALNUT	COVE HEALTH AND REP	ABILITATION CENTER		WALNUT COVE, NC 27052		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ULD BE COMPLETION	
	1					
E 000	Initial Comments		E 000			
	was conducted on 6/2 found in compliance related to E-0024 (b)(	VID-19 Focused Survey I/2020. The facility was with 42 CFR §483.73 6), Subpart-B-Requirements acilities. Event ID# RZ6211				
F 609 SS=B	Reporting of Alleged	Violations	F 609	)		6/30/20
	- , , .	se to allegations of abuse, or mistreatment, the facility				
	involving abuse, negli- mistreatment, includir source and misappro- are reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not res the administrator of the officials (including to the adult protective service for jurisdiction in long	that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ces where state law provides -term care facilities) in e law through established				
	designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective	the results of all administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified a action must be taken.				
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

**Electronically Signed** 

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.

06/21/2020

PRINTED: 07/01/2020

OLIVIEN		MEDICAID SERVICES				NO. 0938-03	
STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         IND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         345089         NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			C 06/01/2020		
			STREET ADDRESS, CITY, STATE, ZI		0/0 1/2020		
				511 WINDMILL STREET			
WALNUT	COVE HEALTH AND RE	HABILITATION CENTER		WALNUT COVE, NC 27052			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE	
F 609	Continued From page 1		F	609			
	by:						
	Based on record review and staff interview the			The Executive Director			
	facility failed to report abuse allegations within 2			Director of Nursing regarding the reporting			
		of the allegation and within 5		time frames related to F-	-tag 609.		
	business days to the state. This was for 1 of 1 alleged abuse investigations completed by the			The Executive Director a	und the Diverten of		
	facility.			Nursing reviewed all rep			
	laointy.			reported to the state age			
	The findings included:			to present for accuracy of			
	5			the allowed time frames			
	The state abuse polic	cy that is used by all facilities		F-609.			
	"Allegations of Abuse	e, Neglect, Exploitation or					
		revised date of 4/18/18		The Regional Director of			
	included in part: "1.	-		educated the Executive			
	involving abuse, neg	-		Director of Nursing rega			
	mistreatment, including injuries of unknown			the state agencies all ev criteria in regulation F-60			
	source and misappropriation of resident property,			specified time frames on			
	are reported immediately, but not later than 2			specified time frames of	10-0-20.		
	hours after the allegation is made, if the events that cause the allegation involve abuse or result			The Executive Director a	and/or the Director		
	in serious bodily injury, or not later than 24 hours			of Nursing educated all			
	if the events that cause the allegation do not			regarding the importance			
	involve abuse and do not result in serious bodily			reporting to the Executiv			
	injury, to the Administrator of this facility and to			the Director of Nursing a	iny events		
	other officials (including the State Survey Agency			involving abuse, neglect	-		
	and adult protective services where state law			misappropriation of resid	lent property by		
	provides for jurisdiction in long-term care			6-30-20.			
	facilities) in accordance with State law through			A monitor was put into p	less to track the		
	established procedures"			A monitor was put into p reporting to the state age			
	Review of the abuse investigations since the last			events involving abuse,	•		
	annual recertification revealed one investigation			exploitation or misappro			
	that was not reported according to the facility			resident property. This i	-		
	abuse policy.			reviewed every Monday			
				3 months, then weekly for			
	a. An initial allegation of resident to resident			monthly for 2 months. R	-		
	-	by Resident #1 to an aide		was also added to the de	-		
		nurse on 11/4/19 at 5:45 AM.		manager stand up meet			
	Resident #1 had stat	ed that her roommate,		for heightened awarenes	ss to events and		

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CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345089		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		345089				C / <b>01/2020</b>	
		STREET ADDRESS, CITY, STATE, ZIP CODE					
WALNUT COVE HEALTH AND REHABILITATION CENTER				511 WINDMILL STREET WALNUT COVE, NC 27052			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 609	Resident #2, had hit I so she had hit her ba revealed the initial all state agency on 11/4, AM-approximately 4 I became aware of the b. An investigation of altercation allegation agency on 11/13/19 a the facility became aw resident allegation. Interview with the Adi Nursing (DON) on 6/7 the Administrator und every abuse allegation	her on the arm and abdomen ck. Review of the report egation was faxed to the /19 at 10:32 hours after the facility incident. the resident to resident was faxed to the state at 12:47 PM - 6 days after ware of the resident to ministrator and Director of 1/2020 at 10:40 AM revealed lerstood the regulation that on should be reported within and within 6 days of DON had simply	F 609	reporting of events. The results of the monitor will b to the Quality Assurance Perfor Improvement Committee.			

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Facility ID: 923219

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