PRINTED: 11/12/2020 FORM APPROVED OMB NO. 0938-0391

I ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING	B. WING		C 11/02/2020	
	ROVIDER OR SUPPLIER CREEK CENTER			STREET ADDRESS 877 HILL EVERH LEXINGTON, N		1 11/	02/2020
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
E 000	Initial Comments		E	00			
F 000	complaint investigation 10/13/2020 through 1 found to be in compliant.		F	00			
	Control Survey and conducted on 10/13/2 The facility was found CFR §483.80 infection has implemented the Disease Control and recommended practice	ces to prepare for 5 complaint allegations were					
F 580 SS=E	CFR 483.12 at tag F6 A partial extended su 11/02/20 and the sur to 11/02/20. Notify of Changes (In CFR(s): 483.10(g)(14) §483.10(g)(14) Notific (i) A facility must imm consult with the resid		F.	80			11/10/20
ABORATOPY!	representative(s) who (A) An accident involves results in injury and h	•			TITLE		(X6) DATE

Electronically Signed 11/09/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345333	B. WING		C 11/02/2020		
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP COD 877 HILL EVERHART ROAD LEXINGTON, NC 27295			
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F 580	mental, or psychosod deterioration in health status in either life-th clinical complications (C) A need to alter to a need to discontinue treatment due to adv commence a new for (D) A decision to tran resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informati is available and proviphysician. (iii) The facility must resident and the resident an	n; nge in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or si); eatment significantly (that is, e an existing form of erse consequences, or to em of treatment); or esfer or discharge the sility as specified in ification under paragraph (g) the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, en or roommate assignment 10(e)(6); or lent rights under Federal or	F 58	30			

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11/02/2020	
				877 HILL EVERHART ROAD		
ABBOTTS	CREEK CENTER			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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 580	under §483.15(c)(9). This REQUIREMENT by: Based on record rev resident, family, staff Assistant (PA), and facility failed to notify medical provider, or representative when (lower back) surgical care. Resident #2's for greater than 10 ditreatment which resuincision site requiring debridement. This w reviewed for wound of The findings included Resident #2 was adm 9/10/20 with diagnos aftercare following susystem. Resident #2's demorecord indicated emerganily member. A nursing note dated #14 (the Nurse Superwas admitted to the formal record record indicated to the formal record indi	rien its different locations T is not met as evidenced riew and interviews with c, outpatient Physician 's acility Medical Director, the the physician, outpatient the resident 's Resident #2 's lumbar incision re-opened during surgical incision was open ays with no medical lited in an infection in the hospitalization and surgical as for 1 of 3 residents care (Resident #2). d: mitted to the facility on es that included surgical urgery on the nervous ographic sheet in the medical ergency contact #1 was a 9/10/20 completed by Nurse rvisor) indicated Resident #2 facility following a	F 58	This Plan of Correction is prepared a submitted as required by law. By submitting this Plan of Correction, At Creek Center does not admit that the deficiency listed on this form exist, not does the Center admit to any statemed findings, facts, or conclusions that for the basis for the alleged deficiency. The Center reserves the right to challengulegal and/or regulatory or administrat proceedings the deficiency, statemer facts, and conclusions that form the for the deficiency. F580 CFR(s): 483.10(g)(14)(i)-(iv)(15)(1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	bbotts crents, cm The e in ive nts, pasis E) the is to cian, essary been bund center	
	a portion of the verte This note made no m lumbar (lower back): Physician treatment	r spine surgery that removes bral bone called the lamina). nention of Resident #2 's surgical incision. orders from 9/10/20 to #2 were reviewed and		supervisor or designee, audited on 11/3/2020 all current residents admitt the last thirty days to review orders a ensure appropriate treatments are in place. No discrepancies were found discovery with the audit. The Center Nurse Executive. Registered Nurse (nd upon	

Facility ID: 923045

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				877 HILL EVERHART ROAD			
ABBOTTS	CREEK CENTER			LEXINGTON, NC 27295			
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F 580	Continued From page	÷ 3	F 5	80			
	Resident #2 's physic Director) indicated Re hospital from 8/22/20 laminectomy on 8/25/	ated 9/12/20 completed by cian (the facility 's Medical esident #2 was in the through 9/10/20. He had a 20 due to spinal stenosis		supervisor or designee pericheck on all residents from through 11/7/2020 to ensur concerns have been addres appropriate wound care ordered and appropriate notification and documented. Eight comade for any discrepancies discovery with audits.	11/5/2020 re that all skin ssed with ders in place, a completed rrections were		
	causing leg weakness. On 9/14/20 the physician completed an addendum to the history and physical conducted for Resident #2 on 9/12/20. The addendum indicated Resident #2 's lumbar surgical incision was healing well. The admission Minimum Data Set (MDS) assessment dated 9/18/20 indicated Resident #2			(3) The Center Nurse Exec Registered Nurse (RN) sup designee will educate all lid including fulltime (FT), part diem (PRN) and agency, of Change of Condition Policy All staff not in serviced by 1	pervisor or censed nurses time (PT), per n facility by 11/10/20. 11/10/2020, will		
	's cognition was intacted dependent on 2 or motoransfers, toileting, per He required the extermore for dressing. Rurinary catheter, was incontinent of bowel, wound.	ct. Resident #2 was ore staff for bed mobility, ersonal hygiene and bathing. ersonal sive assistance of 2 or esident #2 had an indwelling assessed as always and he had a surgical		be required to complete in- working. The Center Nurse (CNE), Registered Nurse (I or designee will educate all nurses on obtaining wound all wounds, completing a ch condition, completing an in- Risk Management System incident and accident repor by the nursing staff, and no	Executive RN) supervisor I licensed care orders for hange of cident in the (RMS),where ts are created otification to		
	(post-op) outpatient for lumbar laminectomy. Assistant 's (PA) prog 9/28/20 at 10:40 AM, breakdown of the infesurgical incision. His superior (upper) portional malodorous (foul sme inferior portion of the the incision was asset	#2 attended a postoperative ollow up appointment for his The outpatient Physician 's gress note, completed indicated Resident #2 had erior (lower) portion of his staples were intact to on of incision. There was elling) drainage from the incision and breakdown of ssed as at least 2 to 3 cm redness of the skin) of the		physician and resident repr 11/10/20. (4) Within 24 hours of admi complete skin assessment performed by the Center No (CNE), Registered Nurse (For or designee. Orders will be ensure appropriate treatme place, including pain evalual monitoring the wound for in dehiscence. Surgical wound	ission, a will be urse Executive RN) supervisor reviewed to ents are in ation and ufection, and		

Facility ID: 923045

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		345333	B. WING _		1	C 1/ 02/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 877 HILL EVERHART ROAD	•	170272020	
7.220110				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	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 580	concerned the surgishe sent Resident # Department (ED) for further management A general note dated completed by Nurse by Resident #2's ewas sent to the hospoutpatient follow up lumbar surgical incison from his admission on 9/28/20 included assessments, monit lumbar surgical incison. Resident # was mentioned only record: 1) the 9/14/2 his 9/12/20 note in was healing well on general note completindicated she receiv family member reposent to the hospital fappointment due to infected. The hospital record assessment that ind midline lumbar surgiportion of the wound with drainage noted CT scan of the lumbar surgiportion of the lumbar surgiportion of the lumbar surgiportion of the lumbar scan	The PA indicated she was cal incision was infected and 2 to the Emergency revaluation, imaging, and t. d 9/28/20 at 5:03 PM #7 indicated she was notified mergency contact #1 that he bital from his post-op appointment due to his sion being infected. t #2's facility medical record on 9/10/20 through discharge no measurements, nursing oring or treatments of his sion. There were also no related to the surgical incision twice in the facility medical 22's lumbar surgical incision twice in the facility medical 20 physician's addendum to which he indicated the incision 9/12/20 and 2) the 9/28/20 ated by Nurse #14 that ed a call from Resident #2's ring that the resident was from his outpatient follow up his surgical incision being	F	entered into the wound portal Click Care system and asses nursing administration weekly Nurse Executive (CNE), Regi (RN) supervisor or designee, five times weekly for three morning clinical meeting. The include RMS for any new incinew orders for wound care to appropriate treatments are in ensure that notifications were resident representative, physoutside provider if necessary. Nurse Executive (CNE), Regi (RN) supervisor or designee, all change in conditions five tifor three months in the mornin meeting, to ensure that notific made to the resident representative physician and outside provide necessary. All findings will be the Quality Assurance Perforn Improvement Committee on a basis for ongoing compliance Nurse Executive is responsibility implementing the acceptable correction. Quality Assurance Performance Improvement Coresponsible for ongoing compliance 11/10/202	sed by y. The Center istered Nurse will review onths in the e review will dents, and e ensure place, and e made to the ician and . The Center istered Nurse will review imes weekly ng clinical cations were ntative, er if e brought to mance a monthly e. The Center le for plan of e ommittee is oliance.		

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	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD EXINGTON, NC 27295		02/2020
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F 580	consult and was adm Unit (NSU) on 9/28/2 physician indicated placetious Disease (II primary closure of the was pending intraope Resident #2 underwedebridement (remova primary closure of his Wound cultures teste intravenous (IV) antib specialists recomment therapy until at least A review of Resident his 9/10/20 admission indicated his emerged by staff of changes in phone calls with statu. A phone interview wa #2 on 10/16/20 at 9:4 that he depended on with all ADLs, he was on a laxative that cau he needed 2 staff 's care. He reported that facility as he was reconstructed that the stappes came out, he was unable to reconspecific date, but he last shift (7:00 AM to specific NA had work occasions during the was at least a week puthe facility to the host	een for a neurosurgery itted to the Neurosurgery 0. The neurosurgery lans were made with 0) specialists to attempt e wound. Antibiotic therapy erative cultures. On 9/30/20 ent surgical irrigation and al of unhealthy tissue) and s lumbar surgical wound. d positive for E. Coli and piotics were initiated. ID nded to continue antibiotic 11/13/20. #2's medical record from an through 9/28/20 discharge mcy contact #1 was notified a condition as well as weekly	F	580			

C 11/02/2020		BUILDING _	IDENTIFICATION NUMBER:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
		WING	345333		
	EET ADDRESS, CITY, STATE, ZIP CODE HILL EVERHART ROAD INGTON, NC 27295	S ⁻		ROVIDER OR SUPPLIER CREEK CENTER	
	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	ID PREFIX TAG	CY MUST BE PRECEDED BY FULL	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	
		F 580	e about incident. as conducted with Resident (emergency contact #1) on She stated that she spoke quently by phone during his he indicated that on 9/19/20 er and said that sometime of the NAs told him a couple dout" when they were ported that she spoke with the turing Resident #2's facility how his surgical incision was told it was healing well. Is never informed the opened. She indicated that to #2's post-op follow up ter on 9/28/20 and told her to yeas infected and that she was ospital. Schedule with assignments 9/10/20 admission through wealed Resident #2's first frequently NA #1 and NA #2. The sconducted with NA #1 on M. NA #1 stated she was an worked on Resident #2's	#2 's family member 10/16/20 at 8:30 AM. with Resident #2 freq stay at the facility. SI Resident #2 called he during that week one of his staples "poppe turning him. She rep DON several times distay, and she asked healing, and she was She revealed she was surgical incision had the PA from Resident appointment called he the surgical wound with sending him to the hor A review of the staff's from Resident #2 's 99/28/20 discharge resishift NAs were most in A phone interview was 10/16/20 at 11:53 AM agency NA and she with unit (200 hall) on the 9/17/20, 9/19/20 throughts at the simple staff of the staff's from Resident #2 is 99/28/20 discharge resishift NAs were most in the simple staff of the staff's from Resident #2 is 99/28/20 discharge resishift NAs were most in the simple staff of the staff's from Resident #2 is 99/28/20 discharge resishift NAs were most in the simple staff of the staff's from Resident #2 is 99/28/20 discharge resishift NAs were most in the simple staff of the staff's from Resident #2 is 99/28/20 discharge resishift NAs were most in the simple staff of the simple staff in the simple staff of the simple staff in	F 580
			opened. She indicated that t #2 's post-op follow up er on 9/28/20 and told her vas infected and that she was ospital. schedule with assignments 9/10/20 admission through vealed Resident #2 's first frequently NA #1 and NA #2. as conducted with NA #1 on M. NA #1 stated she was an worked on Resident #2 's first shift on 9/16/20, jugh 9/21/20, 9/23/20 through. She indicated she was	surgical incision had the PA from Resident appointment called he the surgical wound w sending him to the horal A review of the staff of from Resident #2 ' s 9/28/20 discharge reshift NAs were most of A phone interview was 10/16/20 at 11:53 AM agency NA and she wunit (200 hall) on the 9/17/20, 9/19/20 through	

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F 580	care to Resident #2 his staples came out incision. She stated Resident #2 in bed staples came out. Sexact date, but she with NA #2 at the tirr informed the Nurse came out, but she w nurse was. NA #1 came out a dressing incision by the nurse During a phone inte that she was familia had no recollection time a couple of his A phone interview w on 10/16/20 at 12:2 recalled Resident #2 appointment (9/28/2 she remembered se noticing that there w it. She stated that she before she left that of a dressing on Resid and she stated that dressing was in place she began her shift #2 stated that she h the dressing as ther for this. She reveale to the physician or r regarding the dressi	at the time that a couple of at the time that she was turning with another NA when the she was unable to recall the believed she was working and the couple of the time. She reported that she conduty right after the staples was unable to recall who the indicated that after the staples of was placed on the surgical education. The view with NA #2 she stated ar with Resident #2, but she of working with him at the	F	580			

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F 580	explained that at the nurse who first app #2 's surgical incises required notification resident representation looking back on the assessed the surgiphysician to determine the second s	e time, she thought that the lied the dressing to Resident ion must have made the ins to the physician and ative. Nurse #2 indicated that is situation she should have cal incision and notified the inne why a dressing was in cian 's order. She further should have notified Resident ione why a dressing was in cian 's order of the incian's order. She further should have notified Resident ione (emergency contact #1) as was conducted with Nurse #3 ione PM. Nurse #3 reported that when Resident #2 's surgical id, but that she had seen it with when she was working with at she had not made any physician or Resident #2 's but the surgical incision as she is who implemented the required notifications. Was conducted with Nurse #5 ione AM. Nurse #5 reported that is the end of her shift she in the end of her shift sh	F 5	80			

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F 580	since there was son dressing. She furth made any notification Resident #2 's reprincision being open explained that she a informed the physic opening since there Nurse #5 indicated incontinent of bowe stools as he was on may have contribute becoming infected. A phone interview with 12:54 PM with Resident #2 and up appointment. She assessment of the libelieved it was infect was drainage on the odor indicative of arof the incision was of surrounding tissue, incision still had state she sent Resident #2 required debridement of the therapy. The PA rewas preventable expondered treatment a likely would have keep incision would have keep the son or the condered treatment at likely would have keep incision would have keep the son or the condered treatment at likely would have keep incision still had state the son or dered treatment at likely would have keep the son or the so	ge 9 essing to a new dry dressing ne drainage on the previous her revealed she had not ons to the physician or essentative about the surgical and a dressing in place. She assumed another nurse had ian of the surgical incision was already a dressing on it. that Resident #2 was a land frequently had loose a laxative (lactulose) which ed to the surgical incision was conducted on 10/16/20 at dent #2 's outpatient PA who cop follow up appointment on dicated that she was familiar do recalled his 9/28/20 follow he stated that based on her numbar surgical wound she cated. She explained that there are dressing which had a foul infection, the inferior portion open with erythema of the and the upper portion of the ples intact. She indicated that the straight to the ED for further them. She stated that do hospitalization, surgical wound, and IV antibiotic ported that she believed this plaining that if she had been aff when the surgical wound the physician could 've and an antibiotic which most explaining another surgery. She	F	580			

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F 580	staff increased his r surgical wound whi important to notify r soon as the wound	tt #2 's immobility, vel, and total dependence on isk for infection in an open ch made it even more nerself or the physician as was identified to be open.	F 5	80			
	An interview was conducted with the DON on 10/19/20 at 3:32 PM. The DON reported that she first learned of Resident #2 's surgical wound opening and the wound infection on 9/28/20 when emergency contact #1 phoned the facility after the resident had been sent to the ED. She indicated she completed an investigation and was unable to determine the exact date the surgical wound opened, but she had determined that the wound opened prior to 9/18/20 as Nurse #2 saw a dressing on the wound on that date. The DON reported that she expected the nurse who first identified that the surgical incision was open to notify the physician to obtain treatment orders and notify the resident 's representative. She indicated that emergency contact #1 was Resident #2 's representative.						
	s Medical Director of stated that he obset incision on 9/12/20 that time. He report surgical incision aft he depended on the wounds to let him, to surgeon's PA known Medical Director ext deferred treatment incisions to the treat that if staff were under	vas conducted with the facility on 10/19/20 at 11:56 AM. He rved Resident #2 's surgical and that it was healing well at ted that he had not seen the er 9/12/20. He indicated that enursing staff who look at the he resident 's surgeon, or the wif there was a problem. The plained that he normally decisions related to surgical ting surgeon. He reported able to get a hold of the vere to call him to obtain					

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		345333	B. WING			11/	02/2020
	ROVIDER OR SUPPLIER			87	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD EXINGTON, NC 27295		
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F 585 SS=D	that he had not been Resident #2 's surgion his stay at the facility and he had not given related to the surgical that he was unaware was open for greater that for a resident with medical issues who houncommon for an inferent for staff to recondition as soon as prevent further complication of the facility and without for the facility stay. §483.10(j) (3) The residents, and other of facility stay. §483.10(j)(2) The residents, and other of facility stay.	e Medical Director revealed informed by staff that cal incision opened during (9/10/20 through 9/28/20) any treatment orders I incision. He also revealed that the surgical incision than 10 days. He stated in immobility and multiple ad back surgery, it was not ection to develop and it was export any changes in wound they were identified to ications. (4) s. ident has the right to voice lity or other agency or entity without discrimination or ear of discrimination or ear of discrimination or ear of staff and of other concerns regarding their LTC dident has the right to and the ompt efforts by the facility to e resident may have, in		580			11/10/20

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, Z 877 HILL EVERHART ROAD LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 585	grievance policy to e of all grievances reg contained in this par provider must give a to the resident. The include: (i) Notifying resident postings in prominer facility of the right to (meaning spoken) or grievances anonymor of the grievance offic can be filed, that is, address (mailing and number; a reasonab completing the reviet to obtain a written de grievance; and the or independent entities be filed, that is, the p Quality Improvemen Agency and State Lo program or protectio (ii) Identifying a Grie responsible for overs receiving and tracking conclusions; leading by the facility; maintainformation associat example, the identity grievances submitte written grievance de coordinating with sta necessary in light of (iii) As necessary, ta	cility must establish a ensure the prompt resolution arding the residents' rights agraph. Upon request, the copy of the grievance policy grievance policy must individually or through at locations throughout the file grievances orally in writing; the right to file busly; the contact information cial with whom a grievance his or her name, business demail) and business phone le expected time frame for w of the grievance; the right ecision regarding his or her contact information of with whom grievances may bertinent State agency, to Organization, State Survey ong-Term Care Ombudsman on and advocacy system; vance Official who is seeing the grievance process, organizations through to their any necessary investigations and in the confidentiality of all led with grievances, for or of the resident for those d anonymously, issuing cisions to the resident; and the and federal agencies as specific allegations; king immediate action to ontial violations of any resident	F	585			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345333	B. WING			С
	100 (100 OD OLIDOLIST	345333	B. WING_			1/02/2020
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	JUE	
ABBOTTS	S CREEK CENTER			877 HILL EVERHART ROAD		
				LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO TIVE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 585	investigated; (iv) Consistent with reporting all alleged abuse, including injund/or misappropria anyone furnishing sprovider, to the admas required by State (v) Ensuring that all include the date the summary statement the steps taken to insummary of the per regarding the reside as to whether the gleonfirmed, any cornitaken by the facility and the date the wright (vi) Taking appropriaccordance with State Survey Agorganization, or loc confirms a violation rights within its area (vii) Maintaining eviresult of all grievance and failed states and failed abuse.	§483.12(c)(1), immediately violations involving neglect, uries of unknown source, ation of resident property, by ervices on behalf of the ninistrator of the provider; and elaw; written grievance decisions grievance was received, a tof the resident's grievance, a tinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not ective action taken or to be as a result of the grievance, atten decision was issued; atte corrective action in ate law if the alleged violation ents is confirmed by the facility by having jurisdiction, such as gency, Quality Improvement allaw enforcement agency for any of these residents' and fresponsibility; and dence demonstrating the exest for a period of no less than tuance of the grievance. AT is not met as evidenced eview, family interview, and actility failed to resolve a do to provide a written for 1 of 1 residents reviewed ident #2).	F	F585 CFR(s): 483.10(j)(1)- (1) Resident #2 was discha (2) An audit was completed Executive Director (CED), 1 days to assure that all griev	rged 9/28/20. by the Center for the past 30	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345333	B. WING _				02/2020
NAME OF PROVIDER O		L			TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD	117	02/2020
ABBOTTS CREEK (ENIEK			LI	EXINGTON, NC 27295		
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A review revised file griev obtain a grievand grievand grievand grievand grievand grievand grievand aftercar system. The adrassessr 's cogn A grieva Resider concern by phone Resider up appoincision also ind the outp #2 's coindicate Director be resolute form grievand docume a descrievand course a descrievand corrector of the form grievand docume a descrievand corrector of the form grievand docume a descrievand file at the file at the form grievand docume a descrievand file at the file	on 7/1/19) indivances or ally written decision, and notificate of the resonant #2 was administrated by the foliation was intained for the Busines on 9/28/20. In the Busines on 9/28/20	o's grievance policy (last cluded, in part, the right to or in writing, the right to ion regarding his/her eation to the person filing the lution within 72 hours. Initted to the facility on es that included surgical argery on the nervous INITIAL DESTRUCTION OF THE PROPERTY OF THE PRO	F	585	resolved with written notification per facility grievance policy on 11/4/20. Aur revealed all grievances were resolved written notification provided. (3) The Center Executive Director or designee will educate staff on the grievance policy and procedures by 11/10/20. (4) The Center Executive Director and Social Services Director will be responsible for timey review of all grievances, resolutions and written notifications. The Center Executive Director will be responsible for auditing grievances 5x weekly for 1 month, then weekly for 3 months. The Center Executive Director will review the audits, and results will b reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee responsible for ongoing compliance. Date of compliance 11/10/2020	n 3x e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345333	B. WING _			C 11/02/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	'	11102/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 585	undated, indicated to pinpoint the date the The DON reported to conducted with nurse documentation of worth notification. There we investigation related his outpatient followed ocumentation from A phone interview worth was 30 AM with Resides She stated that she summary of the gries 9/28/20 grievance. The DON by phone are ported her concerniformed her that she when Resident #2 opened, but that she correction plan, so the repeated. The family never received any	the DON was unable to be surgical incision opened. That an inservice was to be sing staff related to ounds and physician/family was no information on this door to be surgical incision on this door to appoint the facility. It is family member to a written be a conducted on 10/16/20 at lent #2 's family member. In ever received a written be a was unable to determine the same to the BOM and the DON one was unable to determine the was unable to determine the was implementing a surgical incision first the was implementing a surgical incision on why Resident outpatient appointment without	F 5			
	on 10/16/20 at 4:40 unaware that writter decision was require reporting party for a grievance reported member was review acknowledged that form titled, "Resolut blank. She stated section of the grieval."	vas conducted with the DON PM. She revealed she was n notice of the grievance ed to be provided to the Il grievances. The 9/28/20 by Resident #2 's family ved with the DON. The DON the section of the grievance ion of grievance/concern" was that she forgot to fill out this ence form. She explained that the grievance, but was unable to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345333	B. WING			02/2020	
NAME OF PROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	02/2020	
ABBOTTS CREEK CENTER			877 HILL EVERHART ROAD			
			LEXINGTON, NC 27295			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFII TAG		BE	(X5) COMPLETION DATE	
F 585 Continued From page 16 determine when Residen and that she informed Re member of this information revealed she had not prove related to this grievance to writing. The DON further looked into the portion of indicated Resident #2 was appointment with no doct facility. She was unable to not been addressed. F 600 Free from Abuse and Neg CFR(s): 483.12(a)(1) §483.12 Freedom from A Exploitation The resident has the right neglect, misappropriation and exploitation as define includes but is not limited corporal punishment, involved any physical or chemical treat the resident's medical treat the resident's medical freat the resident's medical systems. §483.12(a) The facility medical systems abuse, corporal involuntary seclusion; This REQUIREMENT is by: Based on record review resident, family, staff, out Assistant, and facility Medical neglected to assess, mor communicate and provide lumbar (lower back) surgifical ing and prevent completed to assess.	at #2 's incision opened esident #2 's family on by phone. She evided any information to the family member in er revealed she had not it the grievance that as sent to his outpatient umentation from the to explain why this had glect Abuse, Neglect, and at to be free from abuse, of resident property, ed in this subpart. This is to freedom from coluntary seclusion and restraint not required to eal symptoms. Bust- Bright mental, sexual, or punishment, or not met as evidenced and interviews with treatient Physician 's dical Director, the facility nitor, document, e medical treatment to a ical incision to promote		F600 CFR(s): 483.12(a)(1) (1) Resident #2 was discharged 9/28/2020. (2) The Center Nurse Executive (CNE and designee will audit the last thirty		11/10/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345333	B. WING _				02/2020
NAME OF P	ROVIDER OR SUPPLIER	0.0000	1		REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	02/2020
NAME OF T	TO VIDER OR GOL LEEK						
ABBOTTS	CREEK CENTER				7 HILL EVERHART ROAD		
				LE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 17	F 6	000			
F 600	s lumbar surgical incidays which resulted in site requiring hospital admitted to the hospit lumbar surgical wounthe wound) with infect debridement of the luperformed. The facilitimplement preventatives, who was at high reprevent the developm ulcer. This was for 1 reviewed for wound of the findings included 1. Resident #2 was an 9/10/20 with diagnose aftercare following surgives, spinal stenoses spaces within your sponthe nerves that transparses. A nursing note dated #14 (the Nurse Superwas admitted to the falaminectomy (a major a portion of the vertex Resident #2 was aler place, time, and situate had soiled dressin fold of buttocks and cotto as the tailbone). Terminal requirements and situate to as the tailbone).	sion was not treated for 18 In an infection in the incision ization. Resident #2 was tal and was diagnosed with d dehiscence (reopening of tion and a surgical Imbar incision was y also neglected to we measures for Resident isk for pressure ulcers, to ment of an ankle pressure of 3 residents (Resident #2) are. : dmitted to the facility on test that included surgical regery on the nervous sis (a narrowing of the mine, which can put pressure vel through the spine), and 9/10/20 completed by Nurse revisor) indicated Resident #2 acility following a respine surgery that removes prial bone called the lamina). It and oriented to person, tion. Nurse #14 indicated gs to his left buttock, inner occyx (commonly referred the dressings were removed	F 6	800	of change in conditions, to ensure that notifications to the physician, resident representative s, and if necessary the outpatient medical provider have been completed. No discrepancies were four upon discovery with audits. The Center Nurse Executive, Registered Nurse (RI supervisor and designee performed as check on all residents from 11/5/2020 through 11/7/2020 to ensure that all sk concerns have been addressed with appropriate wound care orders in place and appropriate notification completed and documented. No discrepancies we found upon discovery with the audit. Nurse #14 was educated 1:1 by Corponurse consultant on skin inspection and skin checks. On 11/8/2020, the Center Nurse Executive performed an audit of current residents to review their Brader Scale, and identify residents that are a risk for pressure ulcers, and ensure the preventative measures are in place. To corrections were made for discrepancie found upon discovery with audits. (3) Abuse and neglect for all staff started on 10/30/20 and completed 11/6/2020. Education for all licensed nurses including fulltime (FT), part time (PT), per diem (PRN) and agency on skin inspection askin checks was started on 10/30/20. Ilicensed nurses including fulltime (FT), part time (PT), per diem (PRN) and	nd er N) skin in e, ere rate d t t t t wo es ed ling and All	
	(MASD) to these area	e Associated Skin Damage as. This note made no #2 ' s lumbar (lower back)			agency will complete a course in vital learn on pressure ulcer prevention and management. All staff that have not completed the course by 11/10/2020, vbe required to complete the course price.	vill	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING			C 1/02/2020
NAME OF P	ROVIDER OR SUPPLIER	1	1	STREET ADDRESS, CITY, STATE, ZIP CODI		
				877 HILL EVERHART ROAD		
ABBOTTS	CREEK CENTER			LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From page	e 18 ated 9/10/20 completed by	F 60	to working. The Center Nurse	Executive	
		e Supervisor) indicated the		(CNE), Registered Nurse (RN		
	following skin condition			or designee will educate all lic	, .	
	- Bruises to left abdo			nurses including fulltime (FT),		
	- Discoloration to righ			(PT), per diem (PRN)and age		
	- Abrasion to left abd			facility Change of Condition P	-	
		between medial buttock fold,		11/10/20. All staff not in service		
	and coccyx	, , , , , , , , , , , , , , , , , , , ,		11/10/2020, will be required to	•	
	•	t made no mention of		in-service prior to working. Th		
	Resident #2 's lumba	ar surgical incision.		Nurse Executive (CNE), Regis		
		_		(RN) supervisor or designee v	vill review all	
	On 9/10/20 a care pla	an was initiated for Resident		change in conditions 5 times v	weekly for	
	#2 with a focus area	related to the risk for skin		three months in the morning of	linical	
	breakdown and actua	al skin breakdown. He was		meeting, to ensure that notific	ations were	
	noted to have MASD	. The goal was for healing of		made to the resident represer	ıtative,	
	Resident #2 's skin i	mpairment. The		physician and outside provide	r if	
		l on 9/10/20 included:		necessary. The Center Nurse		
	- Pat skin when dryin			(CNE), RN supervisor or design		
	- Apply barrier cream			educate all licensed nurses in	-	
		tion daily with Activities of		fulltime (FT), part time (PT), p		
		re and report abnormalities		(PRN)and agency on obtaining		
	- Weekly skin check I	by nurse		care orders for all wounds, co		
				change of condition, completing incident in RMS, and notification	on to	
	_	sion assessment dated		physician and resident repres	•	
		y Nurse #14 (the Nurse		11/10/20.All staff not in service		
		Resident #2 was admitted		11/10/2020, will be required to	•	
		st-op) care status post		in-service prior to working. Wi		
	_	s assessed with bilateral		hours of admission, a complet		
	· ·	ness and he had a urinary		assessment will be performed	•	
		ed Resident #2 ' s skin was d bruising to left abdomen		Center Nurse Executive (CNE Registered Nurse (RN) superv		
	•	asion to left abdomen, and		designee. Orders will be revie		
		id coccyx. There were no		ensure appropriate treatments		
		conditions noted. She		place, including pain evaluation		
		Resident #2 ' s lumbar		monitoring the wound for infec		
	surgical incision.	. toolaont //2 o lambai		dehiscence. Surgical wounds		
	2			entered into the wound portal		
	Physician treatment	orders from 09/10/20 to		Click Care system and assess		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		345333	B. WING _			11/	02/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
	ADEE1/ AENITED			87	77 HILL EVERHART ROAD		
ABBOITS	CREEK CENTER			LE	EXINGTON, NC 27295		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 19	F 6	800			
	9/28/20 for Resident #				nursing administration weekly.		
		no orders related to Resident					
	#2 's lumbar surgical	incision.			(4) The Center Nurse Executive (CNE)	,	
	A 1				Registered Nurse (RN) supervisor or		
		I dated 9/12/20 completed			designee will review five times weekly	or	
	by Resident #2 's phy	sician (the facility is indicated Resident #2 was			three months in the morning clinical		
	,	22/20 through 9/10/20. He			meeting. The review will include Risk Management System (RMS) for any ne	2 / A /	
	•	1 8/25/20 due to spinal			incidents, and new orders for wound ca		
		weakness. The Nursing			to ensure appropriate treatments are in		
		me specified, indicated			place and ensure that notifications wer		
	. ,	o be turned, he slept a lot,			made to the resident representative,		
		bowel, and when they sat			physician and outside provider if		
	him up yesterday he v	was only able to tolerate 5			necessary. The Center Nurse Executiv	е	
	minutes before needing	ng to lay back down. The			(CNE), Registered Nurse (RN) supervise		
		e woke Resident #2 up for			or designee will review new admissions		
		was noted to be alert and			daily for three months to identify reside	nts	
		ace, and time. He was			at risk for pressure ulcers and ensure		
	noted to be able to me				preventative measures are in place. The	ie	
		gs. He was unable to turn by			Center Nurse Executive (CNE),		
	himself.				Registered Nurse (RN) supervisor, will	200	
	On 9/14/20 the physic	cian completed an			review in weekly Clinical At Risk meetir (CAR) with the interdisciplinary team a	-	
		ory and physical conducted			significant changes that identify resider		
		12/20. The addendum			newly at risk for pressure ulcers. All	113	
		's lumbar surgical incision			findings will be brought to the Quality		
	was healing well.	. · · · · · · · · · · · · · · · · · · ·			Assurance Performance Improvement		
	J				Committee on a monthly basis for ongo	oing	
	On 9/17/20 a weekly s	skin check was ordered to			compliance. The Center Nurse Executi		
		cumented during the day			is responsible for implementing the		
		d on the schedule with			acceptable plan of correction. Quality		
		44 was assigned to Resident			Assurance Performance Improvement		
		t on 9/17/20. There were no			Committee is responsible for ongoing		
		ted 9/17/20 and the section			compliance.		
		inistration Record (TAR)			Date of compliance 11/10/2020.		
		e to sign off when the skin					
		ing documentation was					
	completed was blank.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345333	B. WING _			C 11/02/2020
	ROVIDER OR SUPPLIER CREEK CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	's cognition was intano rejection of care. on 2 or more staff for toileting, personal hydrequired the extensive dressing. Resident #catheter and was assof bowel. He was admedications and PRN self-reported frequen 0-10. Resident #2 was wounds and MASD. On 9/22/20 a care plainitiated for Resident indicated that he was related to hospitalized surgery, and limited resident #2 to improfunctioning with ADLs included, in part: - Monitor for decline in Provide cueing for sea A skin assessment do completed by Nurses injury was identified. Resident #2 with a proposition of the infection of the infectio	num Data Set (MDS) 18/20 indicated Resident #2 ct. He had no behaviors and Resident #2 was dependent bed mobility, transfers, giene and bathing. He e assistance of 2 or more for 2 had an indwelling urinary ressed as always incontinent ministered scheduled pain N pain medications and t pain at a 7 on a scale of as assessed with surgical He had no pressure ulcers. an related to ADL care was #2. The focus area dependent for ADL care tion, sepsis, post-op back mobility. The goal was for we current level of s. The interventions In ADL function rafety and sequencing ated 9/24/20 at 3:00 PM #1 indicated a new skin Nurse #1 assessed ressure ulcer to the left outer mention of Resident #2 ' s	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345333	B. WING				C 02/2020
	ROVIDER OR SUPPLIER CREEK CENTER		1	8	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD EXINGTON, NC 27295	1 11/	02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	malodorous (foul smeinferior portion of the the incision was assedeep with erythema (surrounding tissue. To concerned the surgic she sent Resident #2 Department (ED) for further management. A general note dated completed by Nurse a by Resident #2's far sent to the hospital frofollow up appointmen incision being infecte. The hospital record in assessment that india midline lumbar surgic portion of the wound with drainage noted a CT scan of the lumbar showed superficial deportion of the lumbar infection). He was seconsult and was adm Unit (NSU) on 9/28/2 physician indicated plinfectious Disease (II primary closure of the was pending intraope Resident #2 underwed debridement (removal primary closure of his Wound cultures teste intravenous (IV) antibuted.	on of incision. There was belling) drainage from the incision and breakdown of essed as at least 2 to 3 cm redness of the skin) of the The PA indicated she was all incision was infected and to the Emergency evaluation, imaging, and 9/28/20 at 5:03 PM #7 indicated she was notified mily member that he was om his post-op outpatient at due to his lumbar surgical d. Included an ED skin cated Resident #2 had a sall site wound, inferior was dehisced (opened up) and surrounding erythema. A ar spine was obtained which ehiscence of the inferior wound and cellulitis (skin een for a neurosurgery itted to the Neurosurgery 0. The neurosurgery	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED				
		345333	B. WING			C 11/02/2020	
	ROVIDER OR SUPPLIER	1.7777		STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	from his admission of on 9/28/20 included assessments, monitulumbar surgical incision. Resident # was mentioned only record: 1) the 9/14/2 his 9/12/20 note in was healing well on general note completindicated she receive family member reporsent to the hospital fappointment due to infected. A grievance form da #2's family membe Resident #2 had a pon this date and his be infected. The grie assigned to the Dire investigation on 9/28 to be completed by investigation completed indicated: 9/10/20 admission openings to the surging - 9/24/20 skin check openings to the surging - Daily nursing notes surgical incision openings to the surging - Daily nursing notes surgical incision opening surgical surgical surgical surgical surgical surgical surgical surgical surgical su	at #2 's facility medical record on 9/10/20 through discharge no measurements, nursing oring, or treatments of his ion. There were also no related to the surgical 2 's lumbar surgical incision twice in the facility medical 0 physician 's addendum to which he indicated the incision 9/12/20 and 2) the 9/28/20 the by Nurse #14 that and a call from Resident #2 's reting that the resident was rom his outpatient follow up his surgical incision being the 9/28/20 filed by Resident of 9/28/20 indicated ost-op follow up appointment surgical incision was found to evance indicated it was cotor of Nursing (DON) for 10/20 and the investigation was 10/1/20. A review of the sted by the DON, undated, skin check indicated no ical incision note indicated the surgical note by Nurse #1 noted no ical incision shad no documentation of the	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345333	B. WING		C 11/02/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	1119212020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION
F 600	9/27/20 and she incurrence surgical incision was the surgical incision of the surgical incision. The DON spoke we provided). She wo 9/26/20 and she incurrence incision. The DON spoke we provided). This involved with Reside 9/25/20 and she stropen and draining addressing. (Based of assignments and noworked with Residential indicated in this involved in this involved summary of the provided in this involved with summary of the summary of t	rked with Resident #2 on dicated she had not known the as open nor had she observed in. with Nurse #9 (no date rked with Resident #2 on dicated she had not observed in. with Nurse #5 (no date estigation indicated that she ent #2 during the night shift on ated the surgical incision was and she covered it with a dry on the staff schedule with ursing notes, Nurse #5 last ent #2 on 9/23/20 during the d not worked on 9/25/20 as estigation). e investigation indicated that le to pinpoint the date the	F 600		
	assessment and m requested for Resid On 10/15/20 at 1:2 there was no woun for Resident #2 as was not a pressure A phone interview was a 10/16/20 at 9 that he depended owith all ADLs with the explained that he won a laxative that c	th the DON, all wound onitoring information was dent #2 's surgical incision. 7 PM the DON responded that d assessment or monitoring his wound was surgical and			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345333	B. WING_			C 11/02/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	needed to be turned difficulty finding a po Resident #2 reported facility as he was recorded told him that a couple not to worry about it. NAs name or the special cocurred during the PM) and that this special him on multiple occal He reported that it will discharge from the face 9/28/20. He stated to by phone about incidentation he had pain from discharge from his lead unable to determine level after the surgical A phone interview with a frequently by phone She stated that she stream of the NAs told him a popped out when the reported that she special how his surgical she was told it was he that the PA from Resident appointment called he surgical wound with sending him to the head of the NAs hone interview with the surgical wound with the surgical wound with the surgical wound with the phone interview with the phone p	lained that he frequently and repositioned as he had sition that was comfortable. It that during his stay at the eiving care, one of the NAs of his staples came out, but He was unable to recall the ecific date, but he knew it let shift (7:00 AM to 3:00 ecific NA had worked with sions during the first shift. as at least a week prior to his acility to the hospital on the hospital of hospital on the hospital on th	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345333	B. WING _			11/	/02/2020
NAME OF P	ROVIDER OR SUPPLIER	•		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				877 HILL	EVERHART ROAD		
ABBOTTS	S CREEK CENTER			LEXING	TON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	completing the adm required 2 staff 's a reported that she al #2 onto his side and incision (9/10/20). open to air (no dress to be healing nicely admission assessmursing note for 9/1 had not documente #2 's lumbar surgic there was no indicatincision, the number condition of the surgion that have forgotter reported that she recon his buttocks which physician ordered 2 protectant). Nurse observed Resident his admission on 9/ A phone interview woon 10/16/20 at 2:55 Nurse #14 (the Nuradmission for Resident # open to air and app signs of infection or (9/10/20). She repostaples in the incision how many as she hedocumented this infischedule with assigns of sinfection with assigns of higher than the sinfection of the surgical protection of the sur	at she assisted Nurse #1 with hission for Resident #2 as he assistance with care. She and Nurse #1 turned Resident diviewed his lumbar surgical She stated the incision was using in place) and appeared and Nurse #14 reviewed her arent, skin assessment, and 0/20 and revealed that she divided any information on Resident and incision. She reported attention of the length of the are of staples, and/or the agical incision. She stated that have put in her note the condition of the surgical are Supervisor indicated she are to enter this information. She recalled Resident #2 had MASD on the was treated each shift with 2-guard (skin paste #14 stated that she had not #2's surgical incision after 10/20. Was conducted with Nurse #1 of PM. She stated that she and use Supervisor) completed the dent #2. She indicated she 2's surgical incision was beared to be healing with no and the date of his admission or the date of his admission or the had a number of the put she had not known	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345333	B. WING _			C 1 1/02/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 877 HILL EVERHART ROAD LEXINGTON, NC 27295	•	
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F 600	9/25/20) was review revealed that on eith observed a dressing incision. She stated exact date she obsecondition the dressis she remembered we was on his surgical who was working winame) and they had was on the surgical she had not asked a dressing and she had find the dressing as sorders and there we revealed that after scontinued on with his gave no further the dressing was in condition underneat notifying the physici place without a physicated that she was working that she monext and that since dressing to the surgorders change the concision was not her. This interview with hassessment and SE by Nurse #1 that ind a pressure ulcer to lawer ereviewed with that 9/24/20 was who pressure ulcer on the #2. She was asked	9/20/20, 9/24/20, and red with Nurse #1. Nurse #1 her 9/20/20 or 9/24/20 she gon Resident #2 's surgical I that she had not recalled the erved the dressing or what high was in. She indicated that condering why the dressing incision and asking the NA th her (unable to recall a line in not known why the dressing incision. Nurse #1 revealed anyone else about the ad not completed any changes he reviewed the physician 's are no orders for it. She further he saw the dressing she just her work. She explained that thought to figuring out why place, assessing the high the dressing, and/or an of the dressing that was in sician 's order. Nurse #1 so busy when she was eved from one thing to the she had not initiated the ical incision and she had no iressing that this surgical	F	500		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD EXINGTON, NC 27295	1 11/	02/2020
(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 600	left ankle pressure uli was not certain about that she would not ha assessment or SBAR because these were identified skin conditional placed a dressing that this person shoul appropriate document physician. A review of the staff's from Resident #2 's 9/28/20 discharge reshift NAs were most for the staff's from Resident #2 and 10/16/20 at 11:53 AM agency NA and she wounit (200 hall) on the 9/17/20, 9/19/20 through 125/20, and 9/28/20 familiar with Resident the assistance of 2 of the was always inconforced in the second for the worked together Resident #2. NA #1 in care to Resident #2 and his staples came out incision. She stated to Resident #2 in bed we staples came out. She exact date, but she between the second for	der. She stated that she to this. Nurse #1 explained are completed a skin only completed for newly ons and since someone else gon the surgical incision, and have completed the station and notified the was an worked on Resident #2 's first shift on 9/16/20, sugh 9/21/20, 9/23/20 through she indicated she was the station of the station and he ositioning in bed as he was for the stated that 2 NAs gon the 200 hall unit and to provide assistance to revealed she was providing at the time that a couple of of his lumbar surgical	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345333	B. WING		C 11/02/2020		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION		
F 600	came out, but she was. NA #1 came out a dressin incision by the nurs. A phone interview was 10/16/20 at 10:50 A on Resident #2 's ton 9/10/20 through 9/18/20, 9/21/20 the 9/27/20. She indican Resident #2 stating assistance of 2 or rowas always inconting frequent repositioniturn himself. She can that the NAs assign together to provide stated that she had with Resident #2 at staples came out. It cooperatively worked dates to provide careported that she rehaving a dressing of she worked with him when she first saw. A phone interview won 10/16/20 at 12:2 was an agency nurst he facility in Septems chedule with assign documentation, Nur Resident #2 during 9/18/20. Nurse #2	on duty right after the staples was unable to recall who the indicated that after the staples g was placed on the surgical e. was conducted with NA #2 on M. NA #2 stated she worked unit (200 hall) on the first shift 9/13/20, 9/15/20 through rough 9/24/20, 9/26/20, and ated she was familiar with that he required the more staff for most ADLs, he ment of bowel, and he required ng in bed as he was unable to confirmed NA #1 's statement and to the 200 hall worked care to Resident #2. NA #2 no recollection of working the time a couple of his She indicated she had ed with NA #1 on multiple re to Resident #2. NA #2 emembered Resident #2 on his surgical incision when m, but she was unable to recall	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	1 '	(X3) DATE SURVEY COMPLETED	
		345333	B. WING _		1	C 1/02/2020	
	ROVIDER OR SUPPLIER CREEK CENTER			STREET ADDRESS, CITY, STATE, ZIP C 877 HILL EVERHART ROAD LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	(9/28/20). Nurse #2 remembered seeing that there were no pl stated that she asked she left that day (Nurdressing on Resident she stated that she is dressing was in place she began her shift the she had not removed there was no physicial revealed that she to out why the dressing assessed the conditional underneath the dress the physician of the without a physician that looking back on have assessed the she physician to determine with no physician revealed that the DC days ago about Resident with the dressing assessed the she saw the dressing surgical incision where y18/20. A phone interview whom 10/16/20 at 11:40 schedule with assign documentation, Nurse Resident #2 during the y15/20, 9/16/20, 9/26/20, 9/	op follow up appointment explained that she the dressing and noticing hysician 's orders for it. She d the day shift nurse before rese #3) why there was a t #2 's surgical incision and had not known why the e and that it was on when that morning 9/18/20. Nurse had not recalled if there was dressing. She stated that d or replaced the dressing as an 's order for this. She ok no further action to figure I was in place, she had not on of the surgical incision using, and she had not notified dressing that was in place is order. Nurse #2 indicated the situation she should surgical incision and notified dremine why a dressing was in the situation she should surgical incision and notified dremine why a dressing was in the situation she should surgical incision and notified the situation she should should be as order. Nurse #2 in had asked her several ident #2 's surgical incision, date, and she told her that g in place to Resident #2 's en she worked with Nurse #5 AM. Based on the staff inments and nursing se #5 was assigned to the night shift on 9/14/20, 20/20, and 9/23/20. She not worked with Resident #2	F	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		ON	(X3) DATE SURVEY COMPLETED	
		345333	B. WING			11/0	02/2020
	ROVIDER OR SUPPLIER			STREET ADDRES 877 HILL EVERH LEXINGTON, N			02/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 600	these dates that she unable to recall the ecomplete the treatmer right before change of had 2 NAs (unable to with turning the resid noticed that there was lumbar surgical incision recalled the dressing drainage on it. Nurse remembered thinking the surgical incision it. Nurse #5 reported off of the surgical incision staples were missing to be about 1 cm operincision. She indicat approximation as she measurements or conthe surgical incision. had not looked for an dressing as it was allout she had changed dressing since there previous dressing. Soff to the oncoming nurse surgical incision was have the physician lobuilding that day. No assumed another nuphysician of the surgical the dressing oncoming nurse, and She was asked if she	#5 stated that on one of worked with Resident #2, exact date, she was going to ent of Z-guard to his buttocks of shift. She indicated she or recall the NAs) assist her ent and that was when she as dressing on Resident #2 's ion. She reported that had some "yellowish" er #5 stated that she go that the last time she saw there was not a dressing on at that she took the dressing ision and it looked like 1 or 2 and she approximated there enting of the lower part of the ed that this was just an er had not taken any empleted any assessments of Nurse #5 revealed that she had not taken any enady time for her to leave, at the dressing to a new dry was some drainage on the She stated that she reported entire (unable to recall who was) that Resident #2 's open and that she should look at it if he came into the entire #5 explained that she rese had informed the ical incision opening since dressing on it, so she simply go, reported off to the left when her shift was over.	F	600			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING			C 11/02/2020	
	ROVIDER OR SUPPLIER	1 2.000		STREET ADDRESS, CITY, STATE, ZIP COL 877 HILL EVERHART ROAD LEXINGTON, NC 27295	DE	11/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	required treatment to it was possible she was possible she was an observation. Nurse #5 indicated to incontinent of bowel stools as he was on stated that this may surgical incision bed. A phone interview won 10/16/20 at 8:00 was an agency nurse facility 36 hours per schedule with assign documentation, Nurse #2 on 9/22/20 and 90 She stated that she Resident #2 had a dincision when she we that she would not he surgical incision with A phone interview won 10/16/20 at 10:00 was an agency nurse for 4 days in Septent schedule with assign documentation, Nurse #4 during the day she 9/19/20. The physical on 9/17/20 for Resident with a surgical incision with the was good of the skin of the could not be skin of the could not not be skin of the could not	o his buttocks every shift that worked with him and had not in of the surgical incision. hat Resident #2 was and frequently had loose a laxative (lactulose). She have contributed to the oming infected. as conducted with Nurse #13 AM. Nurse #13 indicated she e and she worked at the week. Based on the staff ments and nursing se #13 worked with Resident //23/20 during the day shift. was unable to recall if ressing on his surgical orked with him. She reported ave assessed or treated the nout a physician 's order. as conducted with Nurse #4 OAM. Nurse #4 stated he e and he worked at the facility her 2020. Based on the staff ments and the nursing se #4 worked with Resident iff on 9/16/20, 9/17/20, and cian 's order for a skin check lent #2 was reviewed with	F6	500			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING				
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	CREEK CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295				
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(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page closed.	÷ 32	F	600			
	on 10/16/20 at 10:20 was an agency nurse facility on 1 date only scheduled with assign documentation she w 9/21/20. Nurse #8 representation of Reside that she completed not on 9/21/20. A phone interview was on 10/16/20 at 12:10 schedule with assign documentation, Nurse Resident #2 on during Nurse #11 reported sl Resident #2. A phone interview was on 10/16/20 at 12:23 schedule with assign documentation, Nurse Resident #2 during th Nurse #10 stated that #2, but she was unabhis surgical incision whim. She explained surgical incision was open, or was clowas certain she had resident had surgical incision was certain she had resident with assign was open, or was clowas certain she had resident she was unabhis surgical incision was open, or was clowas certain she had resident with assign was open, or was clowas certain she had resident was surgical incision was certain she had resident was surgical she was surgical	orked with Resident #2 on ported that she no ant #2, but she was certain to treatments for any resident so conducted with Nurse #11 PM. Based on the staff ments and nursing a #11 was assigned to go the day shift on 9/16/20, he had no recollection of the staff ments and the nursing a #10 PM. Based on the staff ments and the nursing a #10 was assigned to be day shift on 9/27/20. The she remembered Resident the to recall what condition was in when she worked with the didn't know if his open to air, was dressed, seed. She stated that she not changed a dressing or ope of treatment to Resident					
	on 10/19/20 at 12:09	s conducted with Nurse #3 PM. Based on the staff nents and the nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345333	B. WING _			C 11/02/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	documentation, Nur #2 on 9/12/20, 9/15/9/28/20. She indical Resident #2 was firsh his surgical incision revealed that she has surgical incision first seen it with a dressi working with him. Shad never changed incision and she has type of assessment, the surgical incision had not seen any phothe surgical incision to her to figure out without an order. Sinever thought about she assumed this hainitiated the dressing. A phone interview won 10/16/20 at 8:23 reached. Based on assignments and nut #6 worked with Reson 9/10/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/24/20, 9/25/20, and A phone interview won 10/16/20 at 11:50 be reached. Based assignments and nut #9 worked with Reson 9/14/20, 9/25/20, and A phone interview won 10/16/20 at 12:44	se #3 worked with Resident (20, 9/18/20, 9/25/20, and ted that she recalled when st admitted to the facility that was open to air. She ad not known when the topened, but that she had ing in place when she was he further revealed that she the dressing to the surgical dinever provided any other monitoring, or treatment to in Nurse #3 explained that she ensystem is orders related to and that it had not occurred why the dressing was in place the further indicated that she in notifying the physician as ad been done by whoever grown as attempted with Nurse #6 AM but she was unable to the staff schedule with ursing documentation, Nurse ident #2 during the night shift 19/13/20, 9/17/20, 9/21/20, 26/20, and 9/27/20. The staff schedule with Nurse #9 AM but she was unable to on the staff schedule with ursing documentation, Nurse ident #2 on 9/12/20, 9/13/2	F 6			

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 877 HILL EVERHART ROAD LEXINGTON, NC 27295		1702/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	#12 worked with Residue the day shift. A phone interview was 12:54 PM with Residue conducted the post-off off off off off off off off off off	e 34 sing documentation, Nurse sident #2 on 9/13/20 during as conducted on 10/16/20 at ent #2's outpatient PA who op follow up appointment on cated that she was familiar I recalled his 9/28/20 follow e stated that based on her mbar surgical wound she ed. She explained that there dressing which had a foul infection, the inferior portion oen with erythema of the and the upper portion of the les intact. She indicated that 2 straight to the ER for further ment. She stated that	F 6				
	debridement of the witherapy. The PA repieves preventable expieves breakdown was identreated with an antibithave kept Resident from having another. A phone interview was on 10/19/20 at 3:32 Finvestigation into whe incision opened was she was unable to pies surgical incision opened was she was unable to pies surgical incision opened was she was unable to pies surgical incision opened werified that Nurse #8 Resident #2 on 9/25/investigation. She resident #2 on She r	as conducted with the DON					

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		345333	B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER	0-2000	1	STREET ADDRESS, CITY, STATE, ZIP COD		11/02/2020	
TO WILL OF T	NOVIBER OR OUT FIER			877 HILL EVERHART ROAD	_		
ABBOTTS	S CREEK CENTER			LEXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 35	F 6	00			
	in which she stated is she saw a dressing of incision on 9/18/20 w. The DON verified that #2 and she was awar surgical incision dress was unable to explain not included in her in interview that indicate Resident #2 when a cand the nurse implemented with the DON indicated NA #1 had two dates prior to 9/1 DON. These dates w. The DON stated that of NAs about the inversion had a dressin NA #1 's interview incision had a dressin NA #1 's interview the Resident #2 when the nurse implemented the incision opened on enthese were the only of Resident #2 prior to sobserved that she expidentified that the surenter an assessment record (EMR), notify treatment orders, entitle EMR, and complete the DON was asked what every nurse who wor observed the surgical	he informed the DON that on Resident #2 's surgical ras reviewed with the DON. It she had interviewed Nurse re that she had seen the sed on 9/18/20. The DON in why this information was vestigation. NA #1 's ed she was working with couple of staples came out mented a dressing was . The staff schedules that worked with Resident #2 on 8/20 were reviewed with the were 9/16/20 and 9/17/20. Is she had not interviewed any estigation and she was mation prior to this date mowledged that based on with the that Resident #2 's surgical ring on it prior to 9/18/20 and at she was working with restaples came out and a red dressing, that the surgical rither 9/16/20 or 9/17/20 as dates NA #1 worked with resident with resident with resident was open to receive the nurse who first regical incision was open to reinto the electronic medical the physician and obtain retreatment orders into the retreatment o					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345333	B. WING _			C 11/02/2020
	ROVIDER OR SUPPLIER CREEK CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	'	11102/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	opened and/or why no physician's order after she completed implemented a new residents admitted withe wound assessed wound portal within surgical wound was documented on wee place to monitor the infection/pain/dehist she began educating processes as well as physician's order for investigation was considered by the start of this survey ("A phone interview with smedical Director of stated that he observincision on 9/12/20 at that time. He report surgical incision after the depended on the wounds to let him or know if there was a Director explained the treating surgeon were unable to get a were to call him to o Medical Director rev	igure out when the incision the dressing was in place with er. The DON reported that her investigation she systemic process for all vith surgical wounds to have I and documented in the EMR 24 hours of admission, the to be assessed and kly, and orders were to be in surgical wound for sence every shift. She stated g staff on these systemic so on the need to obtain a or all treatments after her mpleted. She stated that this een fully completed at the	Fé	500		
	(9/10/20 through 9/2 any treatment orders	ng his stay at the facility 8/20) and he had not given s related to the surgical realed that he was unaware				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED				
		345333	B. WING _			C 11/02/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	than 10 days. He stimmobility and multiback surgery, it was infection to develop and monitoring need nursing staff so that addressed as soon Medical Director ind nurses to assess an sites, notify himself complications, and to for all treatments. b. Physician's orde 9/10/20 indicated a cushion to chair, a pmattress to bed, and Thursdays during the On 9/17/20 a weekly be completed and d shift (7:00 AM - 7:00 schedule with assignassigned to Resider 9/17/20. There were 9/17/20 and the sec Administration Reconurse to sign off who nursing documentate blank. The admission Minimassessment dated 9/15 cognition was intano rejection of care. on 2 or more staff for	sion was open for greater ated that for a resident with ple medical issues who had not uncommon for an and that regular assessments led to be conducted by the any complications could be as they were identified. The icated that he expected the d monitor surgical incision or the surgeon of any o obtain a physician 's order or some redistribution ressure redistribution at skin check weekly on the 7:00 AM to 7:00 PM shift. If skin check was ordered to occumented during the day of PM). Based on the aments, Nurse #4 was that #2 during the day shift on the no skin assessments dated the another than the skin assessment and son was completed was the skin assessment and son was completed was the skin assessment and son was completed was dependent to bed mobility, transfers, regiene and bathing. He	F 6				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345333	B. WING		C 11/02/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	1110112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 600	required the extensi dressing. Resident catheter and was as of bowel. He had no risk for pressure ulcomes assessment (CAA) this 9/18/20 MDS in risk for pressure ulcomes taff assist for ADLs. A Braden Scale, an pressure ulcer risk, 10:38 AM by Nurse at high risk for pressincluded the following a high risk for pressincluded the following assist for ADLs. A complete pain or discontinuous formation of the properties of the pro	we assistance of 2 or more for #2 had an indwelling urinary seessed as always incontinent or pressure ulcers, but was at ters. The Care Area related to pressure ulcers for dicated Resident #2 was at ters and skin breakdown due mobility and dependence on so. assessment for predicting completed on 9/20/20 at #9 indicated Resident #2 was sure ulcers. This assessment and commands. Had no h would limit ability to feel or infort.) ty perspiration, urine, etc. ected every time he was (Ability to walk was severely int. Could not bear weight ested into chair or wheelchair.) ely immobile (did not make in body or extremity position	F 60		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345333	B. WING _			C 11/02/2020	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 877 HILL EVERHART 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From pag	ge 39	F 6	00			
	completed by Nurse injury was identified	dated 9/24/20 at 3:00 PM #1 indicated a new skin . Nurse #1 assessed pressure ulcer to the left outer					
	Recommendation) of completed by Nurse was identified on Reflet was noted as a 1 of The physician was reand an order to approtectant) to the arm	Background Assessment lated 9/24/20 at 3:07 PM #1 indicated a pressure ulcer esident #2 's left outer ankle. centimeter (cm) open area. notified on 9/24/20 at 3:25 PM by Z-guard (skin paste ea and apply a bunny boot (a wraps around the foot to le.					
		dated 9/24/20 indicated ankle three times daily and					
	skin breakdown was interventions of offlo						
	#2 's family membe She stated that she contacted for any ch resident. She repor contacted by one of Resident #2 develop left ankle. The famil spoke with the Direct phone about the pre-	as conducted with Resident r on 10/16/20 at 8:30 AM. was the person the facility ranges in condition with the ted that on 9/24/20 she was the nurses and informed bed a pressure ulcer on his ly member indicated that she eter of Nursing (DON) by ressure ulcer 's development ed her that there were times					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	ATE SURVEY DMPLETED
		345333	B. WING _			C 11/02/2020
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	, CITY, STATE, ZIP CODE ART ROAD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	member stated that other preventative meduce the risk of preventative meduce the risk of preventation of the pressure ulcer on Resident #2 was at 18 She indicated the Down other preventation implemented prior to pressure ulcer on Resident with a sign of the pressure ulcer on Resident with a sign of the preventation, Nurse and agency nurse for 4 days in Septems of the days in Septems of t	to get out of bed. The family she asked the DON why heasures were not in place to ressure ulcer development as high risk for skin breakdown. DN was unable to explain we measures had not been the development of the resident #2 's left ankle. The as conducted with Nurse #4 of AM. Nurse #4 stated he re and he worked at the facility of the staff of the staf	F 6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345333	B. WING _			C 11/02/2020
	ROVIDER OR SUPPLIER CREEK CENTER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	<u>'</u>	11/02/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	obtained an order for ankle three times dathat the physician all was to be applied to Nurse #1 revealed the interventions for Resident #2 was at and she was unable or other preventative to Resident #2's arthe pressure ulcer on the pressure ulcer development of surgery, immobility, assistance with ADL preventative measure should have been in reduce the risk for put the pressure ulcer on the pre	tified the physician and r Z-guard to the left outer ily and PRN. She reported so indicated a bunny boot the resident 's left ankle. The pressure ulcers to explain why a bunny boot the measures were not in place as conducted on 10/16/20 at the first to explain why a bunny boot to measures were not in place as conducted on 10/16/20 at the first to explain why a bunny boot to measures were not in place as conducted on 10/16/20 at the first to explain why a bunny boot op follow up appointment on it is included that Resident #2 was breakdown and pressure ue to his recent back and dependence on so so she stated that the first to pressure ulcer development. The sylloy20 care plan the first for pressure ulcers, assessment and SBAR that the developed a pressure ulcer.	F6			
F 641 SS=D	The DON was unable measures, such as a		F 6	641		11/10/20

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING			l	02/2020
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/	02/2020
ABBOTTS	CREEK CENTER				77 HILL EVERHART ROAD EXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	resident's status. This REQUIREMENT by: Based on record rev facility failed to have set (MDS) assessme ulcers for 1 of 3 resid for pressure ulcers. The findings included Resident #2 was adm 9/10/20 with diagnose aftercare following su system. A nursing note dated #14 (the Nurse Super had no pressure ulcer A skin assessment da Nurse #14 indicated I ulcers. The admission Minim assessment dated 9/ 's cognition was intac pressure ulcers. The	of Assessments. It accurately reflect the is not met as evidenced liew and staff interview, the an accurate Minimum Data ent in the area of pressure ents (Resident #2) reviewed it: Initted to the facility on es that included surgical argery on the nervous 9/10/20 completed by Nurse rvisor) indicated Resident #2 rs. ated 9/10/20 completed by Resident #2 had no pressure	F	641	F641 CFR(s): 483.20(g) (1) Minimum Data Set (MDS), section Mand V for resident #2 was corrected an modified by the Clinical Reimbursement Coordinator (CRC) on 10/16/20. (2) Center Nurse Executive will conduct an audit of MDS assessments on all current residents with wounds, to ensuraccurate documentation of wounds in section V and section M in the Minimum Data Set (MDS). Any assessment that has not been coded correctly will be modified/significant correction complete by 11/10/20. Audit completed 11/4/202 by Center Nurse Executive (CNE). Two corrections were made for discrepancie found upon discovery with audits. (3) On 11/9/2020 the Center Nurse Executive educated the Clinical Reimbursement Coordinator (CRC) on accuracy and coding of the Minimum D Set (MDS), and ensuring proper documentation/accuracy of any wound	d t t re n ed ed es	
	s 9/18/20 admission I conflicting information CAA indicated that Ro pressure ulcer on his	MDS assessment provided n to the MDS coding. This esident #2 had a stage 3			prior to coding. CRC completed course in vital learn on coding of section M and of the MDS on 11/9/2020. (4) Center Nurse Executive or designed	V b	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1	PLETED
		345333	B. WING_				C / 02/2020
	ROVIDER OR SUPPLIER			87	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD EXINGTON, NC 27295	1 11/	02/2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=D	revealed the CAA related Resident #2 's 9/18/2 assessment was in accompleted the CAA related r	PM via email Director of Nursing (DON) ated to pressure ulcers for 20 admission MDS curate as this resident had in his buttock. She reported build be completed. It is conducted with the MDS 4:16 PM. She stated that AAs for Resident #2 's DS assessment. She related to pressure ulcers esident #2 had no pressure She stated that she must different resident 's ident #2 's pressure ulcer the reported that she was new and to the facility 's cords system and was still the conducted with the DON PM. She stated that she be completed accurately. The MDS Nurse was new to additional training would be MDS accuracy. Comprehensive Care Plan ensive Care Plans cility must develop and mensive person-centered sident, consistent with the th at §483.10(c)(2) and		641	will audit section M and V, of new admission assessments weekly times three months to ensure accurate codin of the assessment, results of these aud will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee responsible for ongoing compliance. Date of compliance 11/10/2020.	dits	11/10/20

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345333	B. WING _			C 11/02/2020	
	ROVIDER OR SUPPLIER CREEK CENTER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	1	11/02/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 656	Continued From pag		F 6	56			
	needs that are identiassessment. The codescribe the following (i) The services that or maintain the reside physical, mental, and required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclute treatment under §48 (iii) Any specialized rehabilitative services provide as a result of recommendations. If findings of the PASA rationale in the reside (iv) In consultation with resident's represental (iv) In consultation with resident's represental (iv) In consultation with resident's profuture discharge. Fawhether the resident's profuture discharge. Fawhether the resident community was assellocal contact agencia entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on record refacility failed to developlan that was accurate.	are to be furnished to attain ent's highest practicable d psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required 8.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). services or specialized s the nursing facility will f PASARR f a facility disagrees with the LRR, it must indicate its ent's medical record. th the resident and the ative(s)- pals for admission and reference and potential for cilities must document 's desire to return to the essed and any referrals to es and/or other appropriate		F656 CFR(s): 483.21(b)(1) (1) Resident #2 was discharged	9/28/20.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING	_			C 02/2020	
NAME OF P	ROVIDER OR SUPPLIER	0.0000		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	11/0	02/2020	
					77 HILL EVERHART ROAD			
ABBOTTS	CREEK CENTER			L	EXINGTON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 656	ulcers. The findings included Resident #2 was adm 9/10/20 with diagnose aftercare following su system. A nursing note dated #14 (the Nurse Super had no pressure ulce noted with Moisture A (MASD) to his left but and coccyx (common tailbone). A skin assessment da the Nurse Supervisor conditions: - Bruises to left abdor - Discoloration to righ - Abrasion to left abdor - MASD to buttocks, is and coccyx Resident #2 's care p with a focus area of the skin breakdown relate MASD, pressure ulce to left side of buttocks The admission Minim assessment dated 9/	ditted to the facility on es that included surgical argery on the nervous 9/10/20 completed by Nurse rvisor) indicated Resident #2 rs on admission. He was associated Skin Damage ttock, inner fold of buttocks ally referred to as the ested 9/10/20 completed by rindicated the following skin men, left knee at elbow omen between medial buttock fold, blan was initiated on 9/10/20 the resident being at risk for ed to actual skin breakdown: er stage 3 and unstageable sc. Sum Data Set (MDS) 18/20 indicated Resident #2 ct. He was assessed with no	F	656	(2) On 11/4/2020 the Center Nurse Executive audited care plans on all current residents with wounds, to ensure care plans reflect the resident surrer condition. No discrepancies were found upon discovery with the audit. (3) On 11/9/2020 the Center Nurse Executive educated the Clinical Reimbursement Coordinator (CRC) on implementing a comprehensive person centered care plan that reflects resident swounds. (4) Center Nurse Executive or designed will audit care plans of residents admitt with wounds, weekly times three month to ensure accuracy of wounds. Results these audits will be reviewed at the monthly Quality Assurance Performance Improvement Committee meeting. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	e ed ns of		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345333	B. WING _		C 11/02/2020
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	1 1102220
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 656	Continued From pag	ge 46	F 6	56	
	revealed the care plaskin breakdown was had no pressure ulcome and the care plan related inaccurate for Residulcers on his buttock have documented a information onto Remistake. The MDS New to care planning electronic medical relearning. A phone interview woon 10/16/20 at 4:40 expected care plans person centered, and and pressure in the care plans person centered, and and pressure in the care plans person centered, and and pressure interview woon the care plans person centered, and pressure interview woon the care plans person centered, and pressure interview was a care plans person centered, and pressure interview was a care plans person centered, and pressure interview was a care plans person centered, and pressure interview was a care plans person centered, and pressure plans person centered, and pressure plans person centered, and pressure plans person centered.	as conducted with the MDS at 4:16 PM. She stated that to skin breakdown was ent #2 as he had no pressure s. She stated that she must			
F 697 SS=E	be conducted with h Pain Management CFR(s): 483.25(k) §483.25(k) Pain Mai	nagement.	F 6	97	11/10/20
	provided to residents consistent with profet the comprehensive pand the residents' go This REQUIREMEN by: Based on record reinterview, and Medic facility failed to cons	sure that pain management is so who require such services, essional standards of practice, person-centered care plan, pals and preferences. T is not met as evidenced view, resident interview, staffical Director interview, the istently evaluate and monitor dent who received routine		F697 CFR(s):483.25(k) (1) Resident #2 was discharged 9/2	28/20.

PRINTED: 11/12/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X'		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 ti Boilebii	_			С	
		345333	B. WING _			1	1/02/2020	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				8	77 HILL EVERHART ROAD			
ABBOTTS	CREEK CENTER			L	EXINGTON, NC 27295			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE	
F 697	Continued From pa	age 47	F 6	697				
	and as needed pai	n medications and failed to			(2) The Center Nurse Executive (CNE)		
	assess a resident '			completed an audit on 11/9/2020 of al	I			
		controlled substance pain			current residents to ensure each pain			
	medication for 1 of			monitoring order has the supplementa				
	reviewed for pain n	nanagement.			documentation that includes a pain so			
					numeric value for the nurses to obtain			
	The findings includ	ed:			each shift. Corrections were made for	•		
	4. Danislant #0	and and the standard for all the same			discrepancies found during the audit.	The		
		as admitted to the facility on oses that included surgical			Center Nurse Executive (CNE) and designee completed a pain assessme	nt		
		surgery on the nervous			on all current residents beginning	III		
	_	nosis (a narrowing of the			11/6/2020 thru 11/8/2020 to ensure the	at		
		spine, which can put pressure			pain needs are being met appropriate			
		travel through the spine), and			One correction was made for	,		
	sepsis.	σ . <i>γ</i>			discrepancies found during the audit.			
		vsician orders, dated 9/10/20,			(3) The Center Nurse Executive,			
	related to pain wer				Registered Nurse (RN) supervisor or			
		g) Baclofen (a muscle relaxer)			designee will educate all licensed nurs			
		aily for muscle spasms			including fulltime (FT), part time (PT),	-		
		tin (a medication which may be			diem (PRN) and agency, by 11/10/20			
		europathic or nerve pain) three			evaluation and monitoring of pain leve			
	times daily for pain	(an over the counter pain			for routine and as needed medication, including prior to the administration of			
	medication) once d	•			controlled substance, and alternative	а		
		(an opioid pain medication)			forms of pain management. All staff r	not		
		eeded (PRN) for moderate to			in serviced by 11/10/2020, will be requ			
		ays (end date of 9/15/20)			to complete in-service prior to working			
	'	,			The Center Nurse Executive, Register			
	A physician ' s orde	er for Resident #2 dated			Nurse (RN) supervisor or designee wi	II		
		ain monitoring was to be			re-educate all licensed nurses includir	ıg		
		nift. This order was entered			fulltime (FT), part time (PT), per diem			
		Medical Record (EMR) by			(PRN)and agency on the correct way			
	Nurse #7.				enter the pain monitoring order in Poir			
					Click Care (PCC) by 11/10/2020. The	:		
		sment dated 9/10/20 at 4:44			order should be for every shift with			
		Nurse #14 (the Nurse			documentation of a numeric value. All			
		sident #2 indicated a pain level 0 - 10 with 0 indicating no			staff not in serviced by 11/10/2020, wi required to complete in-service prior to			
	UI U (UII a SCAIC OI	o - TO WILL O HIUICALING NO	1		required to complete in-Service pholitic	,	1	

Facility ID: 923045

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B WING	B. WING			C	
NAME OF REQUIRED OR OURS US		343333	B. WING_		TDEET ADDRESS SITY STATE TID SORE	11/	/02/2020	
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	ssm	e 48 ent dated 9/13/20 at 1:57 rse #12 for Resident #2	F	697	working. (4) The Center Nurse Executive (CNE) Registered Nurse (RN) supervisor or	Ι,		
indicated a pain The admission Massessment date 's cognition was scheduled pain in medications and 7 on a scale of 0 medication on 6 Assessment (CAMDS assessment he had frequent activities at time Resident #2 was pain and as nee On 9/22/20 a ca Daily Living (AD#2. The focus a dependent for Alsepsis, post-ope and limited mobil #2 to improve cuance ADLs. The inter-Monitor for pain interventions to effectiveness, accordered, and doeffects. - Evaluate and magnior to activity of the review of the residuence and separate and magnior to activity of the review of the residuence and separate and magnior to activity of the review of the residuence and separate and magnior to activity of the review of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and magnior to activity of the residuence and separate and	leve Ininim In d 9/ Inta I				Registered Nurse (RN) supervisor or designee will review new admissions, a any new orders for pain medication in clinical start up Monday thru Friday, on weekends the Registered Nurse (RN) supervisor will review to ensure order f pain monitoring is correctly entered. The Center Nurse Executive or designee we complete five random pain assessmen weekly to ensure that residents pain needs are being met appropriately. The Center Nurse Executive (CNE) will bring the results of the audits to the monthly Quality Assurance and Improvement committee meetings for ongoing compliance. The Center Nurse Executive is responsible for implementing the acceptable plan of correction. Quality Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020.	for ne rill ts e ng		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020		
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F 697	Continued From page completed after 9/13	3/20.	F 6	697				
	admission through 9 each nurse docume shift under the pain was no indication of was experiencing pa MAR indicated Resiroutine Gabapentin,	t #2 's Medication rd (MAR) from his 9/10/20 /28/20 discharge revealed nted a checkmark once per monitoring section, but there whether or not the resident nin. Further review of the dent #2 was administered Tylenol, and Baclofen as xycodone was administered						
	#2 on 10/16/20 at 9: alert and oriented to situation. He indicat admission through of his back. He reporte	as conducted with Resident 49 AM. Resident #2 was person, place, time, and led that he had pain from ischarge from his legs and d he received routine and ns when he was at the facility						
	on 10/16/20 at 3:21 entered Resident #2 order for pain monitor reviewed the order at entered this order st portion of the order that required the nurvalue for pain level was completed. She exp supplemental value that the EMR autom for the nurse to enter	as conducted with Nurse #7 PM. Nurse #7 verified she 's 9/10/20 physician's bring into the EMR. She and stated that when she he forgot to include the called a "supplemental value" se to select a numerical when the monitoring was blained that when this was included on the order atically populated a question or a numerical value for pain hitoring was checked off on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	11/02/2	2020
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ABBOTTS CREEK CENTER			LEXINGTON, NC 27295				
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F 697	Continued From page	e 50	F 6	697			
	monitoring for Reside monitoring was comp any pain present. Sh way to evaluate the e	was no indication of pain					
	on 10/16/20 at 2:55 F recalled Resident #2 was able to voice his levels. When asked for pain monitoring sh documented on the M nurse was required to 0 to 10 for the resider showed a checkmark in the pain monitoring pain level or pain prevented when the pain level or p	Is conducted with Nurse #1 If M. She stated that she was alert and oriented and needs and report pain about the normal protocol ne stated that this was IAR and that every shift the odocument a pain level from nt. Resident #2 's MAR that was documented each shift y section with no indication of sence was reviewed with stated that she had not #2 's MAR had no place to vel. She reported she had e. She acknowledged that a checkmark on the MAR for were unable to tell if pain that the pain level was.					
	on 10/19/20 at 12:09 recalled Resident #2 routine and PRN pair management of leg a that pain monitoring valift and that the nurseither a pain level of yes pain was present was not present). Sh	s conducted with Nurse #3 PM. She stated that she and reported that he had medication for pain nd back pain. She stated vas completed daily each se was required to document 0 to 10 or a "Y" (indicating) or "N" (indicating no pain e reported that if the nurse at they were then required to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295		11/02/2020	
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F 697	document a descrip Resident #2 's MAF was documented ea section with no indic presence was review stated that she had s MAR had no place or pain presence. Sonoticed this before, there was just a che monitoring, you were present and/or what A phone interview w #2 's physician, who Medical Director on Medical Director on Medical Director rep was essential as it w measure whether or interventions in place if a physician 's ord monitoring to be cor he expected this mod documentation of a description of the pa An interview was co Nursing (DON) on 1 stated that pain mor each shift and was ce either a "Y" or "N" w to pain presence or - 10. The DON expl documented a "Y" to then they were to do in the nursing notes this pain monitoring the resident 's pain	tion of the pain in the notes. It that showed a checkmark ich shift in the pain monitoring station of pain level or pain wed with Nurse #3. Nurse #3 not known why Resident #2 ' to document the pain level the reported she had not She acknowledged that since ckmark on the MAR for pain to unable to tell if pain was the pain level was. The pain level was. The pain level was as conducted with Resident to also served as the facility 's 10/19/20 at 1:20 PM. The ported that pain monitoring was utilized as a tool to the pain management to the pain management to the were effective. He reported the was in place for pain inducted daily each shift then initoring to include numerical pain level or a	F 6	97			

` '		IDENTIFICATION NUMBED:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	11/02/2020	
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F 697	section with no indipresence was reviewerified there was ror pain level. The Dwas no way to tell in being managed by on the MAR. She been overlooked whas entered into the second of the managed by on the MAR. She been overlooked whas entered into the second of the managed by on the MAR. She been overlooked whas entered into the second of the managed by on the MAR. She been overlooked whas entered into the second of the managed by on the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the managed by on the nerves that the second of the nerves that the second of the nerves that the second of the nerves that the nerves that the second of the nerves that the nerves that the second of the nerves that the second of the nerves that the nerves that the second of the nerves that the second of the nerves that the nerves that the second of the nerves that the nerves	ach shift in the pain monitoring cation of pain level or pain ewed with the DON. She to indication of pain presence DON acknowledged that there if a Resident #2 's pain was looking at the pain monitoring revealed that this must have then the pain monitoring order	F 69	97		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER		<u>. I</u>	8	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD EXINGTON, NC 27295	117	02/2020
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F 697	Oxycodone was adm description of pain to was administered. On 9/13/20 at 1:07 Fresident 's pain level Oxycodone was adm - On 9/14/20 at 1:28 FOXycodone was adm No pain level was not - On 9/14/20 at 7:29 FOXycodone was adm description of pain to was administered. On 9/15/20 at 9:17 / resident requested Pl the medication was a was noted. On 9/15/20 Resident order from 9/10/20 was administered. On 9/15/20 PRN Oxycod the EMR by Nurse #5 The following eMAR FOXycodone was adm - On 9/15/20 at 9:41 FOXycodone was adm description of pain to was administered. On 9/16/20 at 9:54 / Oxycodone was adm description of pain to was administered. On 9/18/20 at 11:12 resident requested Pl	AM Nurse #6 indicated PRN inistered. There was no indicate why this medication PM Nurse #12 indicated the was a 6 out of 10 and PRN inistered. PM Nurse #9 indicated PRN inistered for lower back pain. Ited. PM Nurse #5 indicated PRN inistered. There was no indicate why this medication AM Nurse #3 indicated the RN Oxycodone for pain and dministered. No pain level #2 's PRN Oxycodone as completed (ordered for 5 or for Oxycodone 5 mg every was implemented. This one order was entered into 5.	F	697			

_ ` · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345333	B. WING		C 11/02/2020	
NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	11/02/2020	
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F 697	resident asked for I administered. The to indicate why this The admission Min assessment dated 's cognition was in scheduled pain me medications and set 7 on a scale of 0-10 medication on 6 of Assessment (CAA) MDS assessment in he had frequent paractivities at times. Resident #2 was to pain and as needed On 9/22/20 a care Daily Living (ADL) of #2. The focus areadependent for ADL sepsis, postoperation limited mobility. The interventions in Monitor for pain. Interventions to alle effectiveness, administration to activity or resident #2 was administration Recoxycodone was administration Recoxycodone was administration Ministration Ministration Recoxycodone was administration Ministration Ministration Recoxycodone was administration Ministration Min	7 PM Nurse #3 indicated the PRN Oxycodone and it was re was no description of pain medication was administered. imum Data Set (MDS) 9/18/20 indicated Resident #2 tact. He was administered dications and PRN pain elf-reported frequent pain at a D. Resident #2 received opioid 7 days. The Care Area related to pain for the 9/18/20 indicated Resident #2 stated in that affected his ability to do He recently had back surgery. In the beautiful back surgery is be monitored each shift for it. Polan related to Activities of care was initiated for Resident in indicated that he was care related to hospitalization, we (post-op) back surgery, and the goal was for Resident #2 to rel of functioning with ADLs.	F 69	7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345333	B. WING _			11/0) 2/2020
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(X4) ID PREFIX TAG			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 697	Continued From pag	e 55	F 6	697			
	description of pain to was administered. - On 9/23/20 at 11:12	-					
	#2 on 10/16/20 at 9:4 alert and oriented to situation. He indicate admission through di his back. He reported	as conducted with Resident 49 AM. Resident #2 was person, place, time, and ed that he had pain from scharge from his legs and d he received routine and as when he was at the facility staff when he was					
	on 10/16/20 at 3:21 Fentered Resident #2 order for PRN Oxycoreviewed the order a entered this order ship the portion of the ordivalue" that required to numerical value for padministration of the explained that when included on the order popped up a question numerical value for poycodone was selefurther explained this onto the resident 's I	ain level prior to the PRN Oxycodone. Nurse #7 this supplemental value was r that the EMR automatically n for the nurse to enter a ain level when PRN cted for administration. She numerical value populated					
	on 10/19/20 at 12:09	as conducted with Nurse #3 PM. Nurse #3 stated that it #2 and reported that he					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/02/2020	
					_ EVERHART ROAD			
ABBOTTS	CREEK CENTER				STON, NC 27295			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 697	management of leg about the normal pr PRN pain medication administration the normal pr resident 's pain on She reported that the on the MAR. Resid no indication an asseconducted prior to to Oxycodone was revisional for leg pain with no assess at 9:17 AM for resid assessment of pain for leg pain with no 9/18/20 at 5:47 PM presence or assess stated that she doct every administration she was unable to every administration she was unable to every administration she was unable to every administration she was not in the medi she needed to spea (DON). On 10/19/20 at 12:57 report by email corr documentation of as Resident #2 prior to Oxycodone from 9/19/23/20 at 11:12 AM following information - On 9/15/20 at 9:47 pain level of 0 prior Oxycodone - On 9/16/20 at 9:54	N pain medication for pain and back pain. When asked otocol for administration of a on she stated that prior to urse had to assess the a numerical scale of 0 to 10. his number was documented ent #2 's MAR that showed sessment of pain level was he administration of PRN riewed with Nurse #3. The es of Nurse #3 's PRN Oxycodone to Resident 1) 9/12/20 at 3:30 PM for foot ment of pain level; 2) 9/15/20 rent request with no level; 3) 9/18/20 at 11:12 AM assessment of pain level; 4) with no description of pain ment of pain level. Nurse #3 umented a pain level prior to not PRN pain medication and explain why this information cal record. She reported that alk with the Director of Nursing 154 PM the DON provided a respondence that showed sessed pain levels for the administration of PRN 15/20 at 9:41 PM to through 15/20 at 9:41 PM to through 15. This report revealed the	F	697				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	11102220		
(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 APPRO DEFICIENCY)	D BE COMPLETION		
F 697	pain level of 0 prior Oxycodone On 9/18/20 at 5:47 pain level of 0 prior Oxycodone On 9/22/20 at 8:50 pain level of 0 prior Oxycodone On 9/23/20 at 11: pain level of 0 prior Oxycodone On 10/19/20 at 12:5 reviewed with the D stated that she was report back to the e unable to explain w any documentation assessed pain level administration of PF was asked if she be Oxycodone for a pa She stated that she and that she had to decision making ski medication was neethat if the resident in any pain, but reque anyway, that the nuthe medication base. A follow up phone in Nurse #3 on 10/19/2 report of assessed prior to the administ showed Nurse #3 a	ge 57 12 AM Nurse #3 indicated a to the administration of PRN 7 PM Nurse #3 indicated a to the administration of PRN 9 PM Nurse #6 indicated a to the administration of PRN 12 AM Nurse #13 indicated a to the administration of PRN 13 AM Nurse #13 indicated a to the administration of PRN 15 PM the above report was nonly able to pull the above vening of 9/15/20. She was hy she was unable to retrieve prior to 9/15/20 related to a for Resident #2 prior to the RN Oxycodone. The DON nin level of 0 was appropriate. The believed pain was subjective depend on her nurse 's alls on whether or not a pain add. The DON further stated andicated they were not having sted the PRN Oxycodone rese may have administered and on the resident 's request. 14 AM Nurse #3 indicated a to the administered was not part of PRN 15 PM the above report was not part of PRN 16 PM Oxycodone. The DON only able to pull the above vening of 9/15/20 related to the prior to t	F 69	7			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345333	B. WING		C 11/02/2020	
NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER			8	TREET ADDRESS, CITY, STATE, ZIP CODE 77 HILL EVERHART ROAD .EXINGTON, NC 27295	12.2020	
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F 697	unable to explain w level of 0 prior to the Oxycodone. She st administer PRN Ox as it was a narcotic indicated it was as a explained that if the medication was not ordered. A phone interview w on 10/19/20 at 4:05 a 0 as the assessed prior to him adminis Oxycodone on 9/16 that this must have have administered l level of 0. Nurse #4 0 meant that the res needed pain medica needed. A phone interview w on 10/16/20 at 8:23 reached. Nurse #6 assessed pain level administering the re 9/22/20 at 8:59 PM. A phone interview w on 10/19/20 at 1:17 reached. Nurse #1 assessed pain level administering the re 9/23/20 at 1:12 AM. A phone interview w	were reviewed. Nurse #3 was hy she documented a pain e administration of PRN tated that she would never ycodone for a pain level of 0 medication and the orders needed for pain. Nurse #3 are was no pain then the being administered as was conducted with Nurse #4 PM. Nurse #4 documented a pain level for Resident #2 stering the resident PRN /20 at 9:54 AM. He stated been an error as he would not PRN Oxycodone for a pain a explained that a pain level of sident was in no pain, so an as action would not have been was attempted with Nurse #6 AM but she was unable to documented a 0 as the a for Resident #2 prior to be sident PRN Oxycodone on was attempted with Nurse #13 PM but she was unable to be 3 documented a 0 as the a for Resident #2 prior to her esident PRN Oxycodone on	F 697			

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NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER		040000		STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	11/02/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			DATE		
F 745 SS=D	assessed pain level fradministering the res 9/15/20 at 9:41 PM. A phone interview ware 2's physician, who Medical Director on 1 stated that he expect pain assessment using prior to the administrated medication. He report was not to be administrated the medical Director a strong narcotic with addiction risks and it it was medically neces Provision of Medically CFR(s): 483.40(d) §483.40(d) The facility medically-related social medically-related social medically-related social medically and psychosocial well this REQUIREMENT by: Based on record revitamily, staff, and outpassistant, the facility the outpatient medical records were sent with postoperative (post-over 10 mills at 10 mills.)	ocumented a 0 as the or Resident #2 prior to her ident PRN Oxycodone on seconducted with Resident also served as the facility 's 0/19/20 at 1:20 PM. He ed the nurses to complete a ang a numerical pain scale ation of PRN pain sted that PRN Oxycodone stered for a pain level of 0. stated that Oxycodone was potential side effects and should not be utilized unless ssary to control pain. A Related Social Service The interviews with the provide is services to attain or coracticable physical, mental libering of each resident. The is not met as evidenced The wand interviews with the provider when no medical the provider when no medical the Resident #2 to his possible possible physical standards.	F 7	F745 CFR(s): 483.40(d) (1) Resident #2 was discharged 9/28/2 (2) All residents with follow up appointments and post op needs have potential to be affected. The Medical record coordinator, and transportation driver will audit all new admissions in til last 30 days for follow up appointments ensure that this care was coordinated a necessary. Audit completed 11/06/202	the he s to as	

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ABBOITS	CREEK CENTER			LE	LEXINGTON, NC 27295		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
F 745	aftercare following susystem. A nursing note dated completed by Nurses indicated Resident #2 following a laminecto that removes a portion called the lamina). The admission Minimassessment dated 9/ 's cognition was intained on 9/28/20 Resident (post-op) outpatient following a laminectomy. Assistant 's (PA) proindicated Resident #2 and had come to the medications or docur. A grievance form dating a family member resident had a post-of this date and no medicate the outpatient provided A phone interview was 300 AM with Resided She stated on 9/28/2 PA contacted her to revealed that the PA #2 was sent to the apdocumentation from the stated on the provided was sent to the apdocumentation from the system.	es that included surgical rgery on the nervous 9/10/20 at 11:01 AM #14 (the Nurse Supervisor) 2 was admitted to the facility my (a major spine surgery n of the vertebral bone um Data Set (MDS) 18/20 indicated Resident #2 ct. #2 attended a postoperative follow up appointment for his the outpatient Physician 's gress note dated 9/28/20 awas a resident at a facility appointment without any mentation. ed 9/28/20 filed by Resident on 9/28/20 indicated the p follow up appointment on ical information was sent to be on his condition. s conducted on 10/16/20 at an t#2 's family member. On Resident #2 's outpatient eport on his status. She informed her that Resident inpointment without any he facility. The family he phoned the facility on	F	745	Three corrections were made for discrepancies found upon discovery wi audit. (3) All licensed nurses including fulltime (FT), part time (PT), per diem (PRN), agency and all transportation drivers where the educated on required medical recorneeded for outpatient medical provider appointments by 11/10/2020 by Center Executive Director (CED) and Center Nurse Executive (CNE). A daily appointment sheet has been created, a sign off section to ensure medical records were sent and received by outproviders. (4) Daily appointment sheets will be audited weekly by the Center Executive Director times three months to ensure compliance. The Center Nurse Executive (CNE), RN supervisor or designee will review new admissions, and any follow needs and appointments in clinical statup five times weekly for three months. findings will be brought to the Quality Assurance Performance Improvement Committee on a monthly basis for ongo compliance. The Center Executive Director is responsible for implementing the acceptable plan of correction. Qual Assurance Performance Improvement Committee is responsible for ongoing compliance. Date of compliance 11/10/2020	e ill ds with side ve vup t All ping	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345333	B. WING			C 1 1/02/2020	
NAME OF PROVIDER OR SUPPLIER ABBOTTS CREEK CENTER			:	STREET ADDRESS, CITY, STATE, ZIP CODE 877 HILL EVERHART ROAD LEXINGTON, NC 27295	Z, STATE, ZIP CODE		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION		
F 745	A phone interview v 12:54 PM with Resi conducted the post 9/28/20. The PA in with Resident #2 ar up appointment. SI outpatient appointm the facility. She ex as normally the phy assessments/meas related progress no appointment with th see what medical tr receiving. A phone interview v Director of Nursing PM. She stated tha a resident went to a appointment was fo the following docum driver for the provid list, relevant progre for the outpatient pr necessary informati send back to the fact this paperwork was and to allow the out medical treatment t A phone interview v on 10/19/20 at 12:0 the normal protocol to an out of facility a face sheet, physicia progress notes, and provider to docume needed, such as, for	ge 61 vas conducted on 10/16/20 at dent #2 's outpatient PA who op follow up appointment on dicated that she was familiar and recalled his 9/28/20 follow he stated that he came to the nent with no paperwork from plained that this was unusual sician 's orders, wound urements, and any other tes were sent to the he resident, so she was able to eatment he had been vas conducted with the (DON) on 10/16/20 at 4:40 at the normal protocol for when an outpatient follow up or the nurse on duty to send then the with the transportation her: face sheet, medication as notes, and a consult form to ovider to document any on on about the resident to cility. The DON indicated that provided to coordinate care apatient provider to know what the resident was receiving. vas conducted with Nurse #3 9 PM. Nurse #3 stated that for when a resident was sent appointment was to send the an 's orders, any relevant that a form for the outpatient at any information the facility of the outpatient of the nurse #3 stated that if this willow up appointments or Nurse #3 stated that if this	F 745				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345333	B. WING			1	02/2020
NAME OF PROVIDER OR SUPPLIER			1 3	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	11/02/2020	
ABBOTTS CREEK CENTER				877 HILL EVERHART ROAD LEXINGTON, NC 27295			
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F 745	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO			