DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				B NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345420	B. WING			C
NAME OF PF	ROVIDER OR SUPPLIER	010120		STREET ADDRESS, CITY, STATE, ZIP CODE	I	03/31/2022
				1987 HILTON ROAD		
ALAMANO	E HEALTH CARE CENT	ER		BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	;	FO	000		
		ation survey was conducted 3/31/22. Substandard dentified at:				
	CFR 483.25 at tag F6 (H)	684 at a scope and severity				
	CFR 483.25 at tag F6 (H)	590 at a scope and severity				
	A partial extended su	rvey was conducted.				
	NC00187392, NC001	86588, NC00187157, 87384, NC00186112, 86554, NC00186336, 00187896. allegations were				
	Tag F690, F684 cons of care.	tituted substandard quality				
F 580 SS=D	Event ID# 9UBI11. Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) ŀ)(i)-(iv)(15)	F 5	.80		4/26/22
	consult with the resid consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical,				
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					04/21/2022

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.

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345420	B. WING				31/2022	
NAME OF PI	ROVIDER OR SUPPLIER		•	ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMANCE HEALTH CARE CENTER					1987 HILTON ROAD BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	SHOULD BE COMPLETION		
F 580	mental, or psychosoc deterioration in health status in either life-thr clinical complications; (C) A need to alter tre a need to discontinue treatment due to adve commence a new forr (D) A decision to trans resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that compris- part, and must specify	ial status (that is, a a, mental, or psychosocial reatening conditions or); atment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and	F	580				

Facility ID: 932930

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/28/20 FORM APPROV OMB NO. 0938-03	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING		C 03/31/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1987 HILTON ROAD		
ALAMANCE HEALTH CARE CENTER		1	BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC	
F 580	Continued From page	o 2	F 580			
1 300			F 580			
		T is not met as evidenced				
	by: Based on record rev	view, resident, staff, nurse		The statements made in the follow	ina	
		sician interviews, the facility		plan of correction are not an admiss	•	
		sident's representative about		and do not constitute an agreemen		
	the changes in medic	cation administration regimen		the alleged deficiencies nor the rep	orted	
		chotic) for 1 of 1 resident		conversations and other information		
	reviewed for notificat	ion (Resident #6).		in support of the alleged deficiencie		
				facility sets forth the following plan		
	Findings included:			correction to remain in compliance		
		admitted to the facility on		federal and state regulations. The	-	
		lesident 6's recent Annual MDS) assessment, dated		has taken or will take the actions se in the plan of correction. The follow		
	1/11/22, revealed that			plan of correction constitutes the fa		
	cognitively intact.			allegation of compliance. All allege		
				deficiencies cited have been or will		
	Record review reveal	led the Psychiatric Nurse		corrected by the date or dates indic		
		risit note dated 2/3/22				
	indicated that Reside	ent #6 had clinical indications				
		duction (GDR) trial. For this		F580		
		NP #1 ordered to reduce		Resident #6⊡s RP was made of aw		
	Zyprexa from 10 mg	to 5 mg by mouth at		the changes in resident⊡s antipsyc	hotic	
	bedtime.			medication.	L_	
	Poviow of the physic	ion's order for Desident #6		A 30-day review will be completed to		
		ian's order for Resident #6 ted 2/3/22 to discontinue		ensure residents□ RP was notified changes were made in the resident		
		outh daily and start Zyprexa		antipsychotic medications.		
	5 mg by mouth daily			Licensed nurses will be educated b	v	
				DON/designee on notification of RF		
	Review of the Medica	ation Administration Record		medications changes including cha		
	(MAR) for Resident #	46 for February 2022		the antipsychotic medications with	-	
	revealed on 2/3/22 th	ne order to discontinue		documentation of the notification in		
		completed as ordered, but		medical record. Any licensed nurse		
	the new order for Zyp			outside agency staff/new hires who		
		AR until 2/16/22. Zyprexa		not educated will not be allowed to	work	
	was not administered	d from 2/4/22 to 2/15/22.		until education is completed.	4	
	Depard review of the	nurseel notes datad		DON/designee will audit progress n		
	Record review of the			and order listing to ensure notificati		
		at Resident #6's family		changes in antipsychotic medicatio	115	

Facility ID: 932930

If continuation sheet Page 3 of 29

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALAMANCE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE Main Difference BURLINGTON, NC 2217 Main Difference Recolution of the provide state of the provide stat			245400			
ALAMANCE HEALTH CARE CENTER 1987 HILTON ROAD BURLINGTON, NC 27217 ON ID TAG SIMMARY STATEMENT OF DEFICIENCIES (EACH OERCENT ALTON YOR LSC IDENTIFYING INFORMATION) Dr. F 580 Continued From page 3 member stated she was not notified about changes for medication administration of Zyprexa and had a concern about possible withdrawal syndrome (unpleasant reaction to abrupt drug ceasing) for the resident. F 580 Record review revealed the Psychiatric Nurse Practitioner (NP#1) visit note, dated 2/17/22, indicated she had a phone conversation with Resident #0's family, apologized for the notification issue. F 580 On 3/28/22 at 9:45 AM during an interview, Resident #0's family, apologized for the notification seture. Completion April 26, 2022 On 3/28/22 at 9:45 AM during an interview, Resident #0's indicated that he received several medications every day and did not know all of them. The resident preferred the staff to notify her daughter about any changes because the "daughter knows better." On 3/28/22 at 1:55 PM, during an interview, H family about medication regreen changes and document it in the medical records. On 3/28/22 at 1:52 PM, during an interview, Director of Nursing (DON) confirmed Nurse #11 had not notified Resident #6's family of changes with her Zyprexa order. The DON expected the staff to notify the family about medication regreen changes and document it in the medical records.			345420	B. WING		
(M4 ID PHEE)TAG SUMMARY STATEMENT OF DEFICIENCIES (EACI DEFICIENCY MUST BE PRECEDED BY FULL REQUIDENCY MUST BE PRECEDED BY FULL TAG ID PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACI ODRECTIVE ACTION OR OULD BE CROSS-REPRECED INFORMATION) ID PREFIX TAG F 580 Continued From page 3 member stated she was not notified about changes for medication administration of Zyprexa and had a concern about possible withdrawai syndrome (unpleasant reaction to abrupt drug ceasing) for the resident. F 580 Record review revealed the Psychiatric Nurse Practitioner (NP#1) visit note, dated 2/17/22, indicated she had a phone conversation with Resident #6's family, apologized for the notification issue. F 580 On 3/28/22 at 9.45 AM during an interview, Resident #6's family, apologized for the notification severy day and did not know all of them. The resident preferred the staff to notify her daughter about any changes baceuse the "daughter knows better." Con 3/28/22 at 1.55 PM, during an interview, Nor 3/28/22 at 1.55 PM, during an interview, the family about medicated that on 2/3/22, NP #1 changed Resident #8's the order for Zyprexa discontinuing 10 mg daily and initiating an order for 5 mg per day. The floor nurse (Nurse #11) had not notified Resident #6's family of changes with her Zyprexa order. The DON expected the staff to notty the family about medication regimen changes and document it in the medication regimen changes and document it not notified resident #6's family of changes with her Zyprexa order. The DON expected the staff to notify the family about medication tanges in the			ER		1987 HILTON ROAD	CODE
 member stated she was not notified about changes for medication administration of Zyprexa and had a concern about possible withdrawal syndrome (unpleasant reaction to abrupt drug ceasing) for the resident. Record review revealed the Psychiatric Nurse Practitioner (NP#1) visit note, dated 2/17/22, indicated she had a phone conversation with Resident #6's family, apologized for the notification issue. On 3/28/22 at 9.45 AM during an interview, Resident #6' indicated that she received several medications every day and did not know all of them. The resident preferred the staff to notify her daughter knows better." On 3/28/22 at 1.55 PM, during an interview, Unit Manager indicated that on 2/3/22, NP #1 changed Resident #6's the order for 5 mg per day. The floor nurse (Nurse #11) who received the new order for 5 mg zyprexa daily and also failed to notify the family about medication regimen changes and document it in the medical records. On 3/28/22 at 11:25 AM, during an interview, Director of Nursing (DON) confirmed Nurse #11 had not notified Resident #6's family of changes with her Zyprexa order. The DON expected the staff to notify the family about changes in the 	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE
it in the chart. DON stated that Nurse #11 left the facility and was not available for an interview. On 3/29/22 at 12:00 PM, during the phone	F 580	member stated she w changes for medication and had a concern all syndrome (unpleasar ceasing) for the reside Record review reveal Practitioner (NP#1) v indicated she had a p Resident #6's family, notification issue. On 3/28/22 at 9:45 Al Resident #6 indicated medications every dat them. The resident pro- daughter about any c "daughter knows bett On 3/28/22 at 1:55 Pl Manager indicated th Resident #6's the ord 10 mg daily and initia day. The floor nurse (the new order failed t for 5 mg Zyprexa dail family about medication document it in the medication of Market Resident #6's the ord 10 mg daily and initian day. The floor nurse (the new order failed t for 5 mg Zyprexa dail family about medication document it in the medication document it in the medication it in the chart. DON s facility and was not an	vas not notified about on administration of Zyprexa bout possible withdrawal nt reaction to abrupt drug ent. led the Psychiatric Nurse isit note, dated 2/17/22, ohone conversation with apologized for the M during an interview, d that she received several by and did not know all of referred the staff to notify her changes because the ter." M, during an interview, Unit at on 2/3/22, NP #1 changed ler for Zyprexa discontinuing ting an order for 5 mg per (Nurse #11) who received to transcribe the new order ly and also failed to notify the ion regimen changes and edical records. AM, during an interview, DON) confirmed Nurse #11 dent #6 ' s family of changes er. The DON expected the ily about changes in the ation regimen and document tated that Nurse #11 left the vailable for an interview.	F 58	have been made to the r Audits will be done 5x we then weekly x 8 weeks, t Results of the audits will Quarterly Quality Assura for further resolution if ne	eekly x 4 weeks, hen monthly x 3. be reviewed at nce Meeting X 2 eeded.

	-	ID HUMAN SERVICES MEDICAID SERVICES				APPROVED 0938-0391	
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		345420	B. WING		03/31/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1		
ALAMAN	CE HEALTH CARE CENT	ER		1987 HILTON ROAD BURLINGTON, NC 27217			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 580 F 607 SS=D	interview, Medical Dir notify the resident's fa medication regimen a On 3/28/22 at 3:30 Pt interview, NP #1 conf expectation for the nu about changes in the regimen. On 2/16/22 resident's family, apol medication administra explained that Reside psychotropic medicati withdrawn syndrome. Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facility implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establist to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff intervit facility failed to impler area of investigation f who had an allegation	rector, expected the staff to amily about changes in it all the time. M, during the phone irmed that it was her urses to notify the family medication administration , NP #1 contacted the logized for no notification of ation changes, and ent #6 received other ions and did not have buse/Neglect Policies -(3) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures ch allegations, and e training as required at t is not met as evidenced iews, record review, the ment the abuse policy in the for 1 of 1 sampled resident in of abuse (Resident #1).	F 58	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	the	/26/22	
	implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff intervi facility failed to impler area of investigation f	icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures ch allegations, and training as required at is not met as evidenced iews, record review, the ment the abuse policy in the for 1 of 1 sampled resident n of abuse (Resident #1).		Resident #1 is no longer a resident in center. Current residents in the center have the	ne		

Event ID:9UBI11

Facility ID: 932930

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION	(X3) DATE SURV COMPLETE	
			A. BUILDING	C		
		345420	B. WING		03/31/2022	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANO	CE HEALTH CARE CENT	ER		1987 HILTON ROAD BURLINGTON, NC 27217		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CON	(X5) MPLETIO DATE
F 607	Continued From page	e 5	F 607	7		
	Review of the policy in Reporting: Abuse/Neglect/Misap 2/11/22, read in part: administrator or designinitiate an investigation includes interviewing involved, and all patient Resident #1 was administrator and all patient Resident #1 was administrator distribution 1/21/22 indicated he A written statement of the Talk Therapist de Resident #1 of verba a male Nurse Aid (N/weren't sick, I would care in his room. The verbal abuse. In a written interview Administrator dated 3 inappropriate languag Resident #1. Na #5 could not be react The facility's Administrator and their investigation: a factor of the facility's Administrator their investigation: a factor of the facility's Administrator and interview with NA #5, interview with Resident letter dated 3/22/22 states of the factor of	titled "Abuse/Investigative opropriation/Crime" revised "section 10: The gnee must immediately on. This investigation all staff involved, any family ents involved." nitted to the facility 7/21/21. m Data Set (MDS) dated was cognitively intact. lated 3/16/22 completed by scribed a report from I abuse on 3/15/22 in which A #5) told Resident #1 "if you beat you" while providing a therapist did not witness the B/17/22, Na #5 denied any ge or comments toward eached for interview. trator and Director of ded the following related to documented telephone , documentation of an ent #1 and his roommate. A submitted to the State e allegation and investigation		Services/designee on the center on abuse and neglect including h conduct a thorough investigation FRIs will be audited by Regional of Clinical Services/designee to thorough investigation was comp weekly x 4 weeks, then weekly x then monthly x 3. Results of the audits will be revie Quarterly Quality Assurance Mee for further resolution if needed. Completion April 26, 2022	now to Director ensure a bleted 3x 8weeks, ewed at	

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ABUILDING B. WING B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST. ALAMANCE HEALTH CARE CENTER BURLINGTON, NC 2721	(X3) DATE SURVEY COMPLETED C 03/31/2022 E, ZIP CODE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST. ALAMANCE HEALTH CARE CENTER 1987 HILTON ROAD	03/31/2022
ALAMANCE HEALTH CARE CENTER 1987 HILTON ROAD	E, ZIP CODE
ALAMANCE HEALTH CARE CENTER	
BUREINGTON, NC 2721	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORREC CROSS-REFERENCE	LAN OF CORRECTION (X5) IVE ACTION SHOULD BE ED TO THE APPROPRIATE DATE FICIENCY)
F 607 Continued From page 6 F 607	
During an interview on 3/29/22 at 10:35 AM, the	
Administrator recalled interviewing Resident #1	
and his roommate following the allegation of	
verbal abuse. She revealed they did not interview	
all residents that NA #5 had worked with, only	
Resident #1 and his roommate. The investigation	
did not include interviews of staff members	
working with NA #5. The Administrator indicated	
that NA #5 was let go and she did not feel the need to interview other residents since the named	
employee no longer worked at the facility. She felt	
all residents involved included Resident #1 and	
his roommate.	
F 656 Develop/Implement Comprehensive Care Plan F 656	4/26/22
SS=H CFR(s): 483.21(b)(1)	
§483.21(b) Comprehensive Care Plans	
§483.21(b)(1) The facility must develop and	
implement a comprehensive person-centered care plan for each resident, consistent with the	
resident rights set forth at §483.10(c)(2) and	
§483.10(c)(3), that includes measurable	
objectives and timeframes to meet a resident's	
medical, nursing, and mental and psychosocial	
needs that are identified in the comprehensive	
assessment. The comprehensive care plan must	
describe the following - (i) The services that are to be furnished to attain	
or maintain the resident's highest practicable	
physical, mental, and psychosocial well-being as	
required under §483.24, §483.25 or §483.40; and	
(ii) Any services that would otherwise be required	
under §483.24, §483.25 or §483.40 but are not	
provided due to the resident's exercise of rights	
under §483.10, including the right to refuse	
treatment under §483.10(c)(6). (iii) Any specialized services or specialized	
rehabilitative services the nursing facility will	

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/28/20 FORM APPROV OMB NO. 0938-03	
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		345420	B. WING		C 03/31/2022	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALAMAN	CE HEALTH CARE CENT	ER		987 HILTON ROAD BURLINGTON, NC 27217		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIC	
F 656	provide as a result of recommendations. If findings of the PASAI rationale in the reside (iv)In consultation wit resident's representa (A) The resident's go desired outcomes. (B) The resident's pre- future discharge. Fac whether the resident' community was asse local contact agencie entities, for this purper (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on record rev and Medical Director to develop and imple when the resident ma condom catheter; wh (activities of daily livir refused full body skin residents, (Resident a arrived at the Emerge significant swelling of his condom catheter medical tape. The ski described multiple ex foreskin with active b discolorations, two sa abrasions over the bo	PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)- als for admission and efference and potential for illities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. n the comprehensive care in accordance with the h in paragraph (c) of this T is not met as evidenced iew, staff, Nurse Practitioner, interviews, the facility failed ment effective interventions anipulated and taped his en the resident refused ADL ng) care; when the resident assessments for 1 of 8 #7). On 3/13/22 Resident #7 ency Department (ED) with i his scrotum and groin and was extensively taped with in assessment in ED coriated lesions to his leeding, multiple skin acral pressure ulcers and ody. One Resident #7's in the nail bed when his	F 656	F656 Resident # 7 is no longer a resident in facility Current residents in the center with documented refusals of ADL care, refusals of skin assessments, manipulation of catheters and providi care to self that could lead to harm to or infection have the potential to be affected. The resident⊡s most recent OBRA MDS completed in the quarter be reviewed for coding of above-mentioned behaviors. Current residents will be reviewed for docume refusals of ADL care, refusals of skin assessments, manipulation of cathete and providing care to self that could le to harm or infection will be care plant	ng self will ented ers ead	

Facility ID: 932930

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/28/2022 RM APPROVED IO. 0938-0391
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	ROVIDER OR SUPPLIER	ER	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 987 HILTON ROAD SURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	1/16/20. His quarterly assessment, dated 12 cognition. Resident # hereditary spastic par legs and lower body), of the urinary bladder adjustment of urinary disorder, and fungal f assessment indicated extensive assistance incontinence of bowe condom (external) car rejection of care 1 to back. Record review of Res dated 3/6/22, reveale behavioral symptoms interventions were to ordered, monitor, and and effectiveness. The resident had an <i>A</i> deficit. The resident of bed, bed baths and in observations and ass effective interventions assistance with ADL. Record review of Res dated 3/6/22, reveale catheter, manipulated wrapped it with tape f interventions were to	hitted to the facility on Minimum Data Set (MDS) 2/4/21, revealed his intact 7's diagnoses included raplegia (paralysis of the , neuromuscular dysfunction r, encounter for fitting and device, major depressive feet infection. The MDS d the resident required with ADL, was always d and bladder, and used a theter. He exhibited 3 days during the 7-day look sident #7's plan of care, d he exhibited adverse as resistive to care. The administer medications as d document for side effects ADL self-care performance often refused repositioning in noontinence care, skin ressments. There were no is related to refusing sident #7's plan of care, d he had a condom d his condom catheter, and regardless of education. The	F	656	addition any behaviors coded on the will be reviewed and care planned. T resident is care plans will be updated include specific interventions to addre and manage the behaviors by April 2 2022. MDS Nurses and Nursing Administra Team was educated by Regional Dire of Clinical Services /designee regard the updating and completion of the comprehensive care plan to reflect th resident is current physical and psychological functioning to include interventions related to behaviors Regional MDS Nurse/ designee will a 5 MDS and care plans for behavior interventions weekly for 5 MDS for we for 4 weeks, biweekly for 8 weeks, ar then monthly times two weekly Results of the audits will be reviewed Quarterly Quality Assurance Meeting for further resolution if needed. Completion April 26, 2022	The I to ess 6, tion ector ng e uudit eekly nd	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345420	B. WING				C 31/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALAMAN	ALAMANCE HEALTH CARE CENTER				987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPLET	
F 656	mm (millimeter) conde below the level of the discomfort in urination due to the catheter. T related to wrapping th possible negative out Record review of Res dated 3/6/22, revealed observations and ass effective interventions refusing skin assessm Record review of Res dated 3/6/22, revealed compression hose ap schedule. The plan of interventions to addre noncompliance. On 3/29/22 at 11:50 A Nurse #12, MDS Nurs responsible for care p resident assessments she worked a long tim #7 and was very fami The plan of care refle interventions for refus medications per order confirmed that the inter plan of care, were dis Nursing (DON), the U mentioned that the eff was limited. Review of the physicia	om catheter bag and tubing bladder, monitor for signs of an and frequency and pain here were no interventions, he condom with tape and comes. bident #7's plan of care, d he often refused skin essments. There were no a to address the resident ments. bident #7's plan of care, d he often refused the plication and removal per f care did not show ess the resident's refusal and M, during an interview, se, indicated that she was blanning and conducting s. Nurse #12 mentioned that he on the floor with Resident liar with his refusal behavior. cted the resident ' s current cal behavior to provide r and monitoring. Nurse #12 erventions, included in the cussed with Director of init Manager. Nurse #12 fectiveness of interventions an's orders for February - lent #7 revealed the orders:	F	656			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED		
		345420	B. WING			C 03/31/2022			
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•			
ALAMANO	CE HEALTH CARE CENT	ER		1987 HILTON ROAD BURLINGTON, NC 27217					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPLETION			
F 656	Continued From page	9 10	F	656					
	revealed that Resider assistance, including baths, and skin asses did not allow the staff catheter, assess his g down or provide cathe constantly manipulate wrapped it with white, provided by the facilit educated about the p his manipulation with same behavior. The r staff to remove the co lower legs at noon, ac order. The staff educa lengthy compression cause numbness, ting Resident #7 would ag staff to remove the ter refused full body skin his back area, and low compression hose ap attempted to offer the the same result. On 3/28/22 at 1:45 Pf Nurse #6, Unit Manag #7 was alert/oriented, decisions. He was kni manipulative behavior diagnoses, the reside and treatment. The In discussed his situatio interventions that wer resident.	genitalia for a skin break eter care. The resident ad his condom catheter and a dhesive tape that was not y. The resident was ossible negative outcome of tape but continued the esident did not allow the ompression hose from his coording to the physician's ated the resident that the hose application could gling, and rashes in the legs. gree but would not allow the d hose. The resident often assessment, skin check of wer legs skin for plication. The staff skin assessment later with							

Facility ID: 932930

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING	B. WING			C 31/2022	
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	·		
ALAMAN	ALAMANCE HEALTH CARE CENTER				1987 HILTON ROAD BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	N SHOULD BE COMPLETIC		
F 656	Nurse #5 indicated th routine ADL care, skir compression hose ap not allow the staff to p catheter care and ma around his condom ca 3/29/22 at 9:00 AM, d Nurse #8 indicated th Resident #7 on third s catheter care and incor resident became agita On 3/9/22, the residen white tape to apply or resident was confused and reminded him that the condom himself a tape from his condom know how the residen On 3/30/22 at 8:30 Af Nurse Aide (NA) #6 in 3/8/22, Resident #7 re brief, refused the bed The resident stated, " On 3/30/22 at 8:40 Af interview, NA #2 indic Resident refused care not allow the staff to t observe resident's up blanket, and the resid observation.	at Resident #7 refused n assessments and plications. The resident did provide overall condom nipulated with white tape atheter very often.	F	656				

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If continuation sheet Page 12 of 29

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345420	B. WING				C / 31/2022
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
					1987 HILTON ROAD		
ALAMANG	CE HEALTH CARE CENT	ER			BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 656	applied the white taped did not want to remove how the resident recet the roll of white tape i On 3/30/22 at 9:30 AF #8 indicated that she first shift of 3/10/22. No several times to offer the resident accepted incomposed come off. The penis, so were dark color, with There was "some red penis without discharge not bother him at all. reported to the floor no Hospital records revie Resident #7 arrived a Department (ED) with scrotum and groin and extensively taped with assessment in ED de lesions to his foreskin multiple skin discolorations ED found an identification his back skin and dur hose a toenail partiall On 3/28/22 at 2:15 Pf Director of Nursing (D #7 was alert, oriented party. His plan of care and behavioral problem	d incontinence care, often e around the condom and re it. NA #7 did not know sived the tape and observed n resident's room. M, during an interview, NA worked with Resident #7 on Aurse Aide #8 attempted the incontinence care and t. At the end of shift, the ontinence care, and the the condom catheter had scrotum and perineal area dry skin and no skin issues. ness" noted on the glans ge. The resident stated it did NA #8 stated this was urse. w revealed that on 3/13/22, t the Emergency n significant swelling of his d his condom catheter was n medical tape. The skin scribed multiple excoriated	F	650	6		

Facility ID: 932930

If continuation sheet Page 13 of 29

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345420	B. WING _				C /31/2022
NAME OF PF	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE	-	
ALAMANC	E HEALTH CARE CENT	ER			187 HILTON ROAD URLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 656 F 658 SS=D	The DON stated rega psychiatric treatment, resistance to care and On 3/28/22 at 3:40 PI interview, Psychiatric indicated that Reside mental status assess and made his own de diagnoses with refusa care/treatment, and n received psychotropic psychotherapy with va adjusted the resident" regimen with limited a behavior. Services Provided Me CFR(s): 483.21(b)(3) §483.21(b)(3) Compre The services provided as outlined by the cor must- (i) Meet professional services This REQUIREMENT by: Based on record revia and physician intervie administer Zyprexa (a ordered by the physic occurred for 1 of 1 res provision of care acco standards (Resident # Findings included:	visodes of adverse behavior. rdless of education and the resident continued his d refusal behavior. M, during the phone Nurse Practitioner (NP #1) nt #7, according to his ment, was cognitively intact cisions. He had psychiatric al, resistance to nanipulative behavior, and c medications and ery little progress. NP #1 s psychotropic medication and temporary effects on his eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. ' is not met as evidenced ew, staff, nurse practitioner, ews, the facility failed to antipsychotic medication) as tian for 12 days. The failure sident, reviewed for the ording to professional		656	F658 Resident #1 is currently receiving medications as per physician orders. A 30 day audit will be conducted to ens residents who are on antipsychotic medications are receiving the antipsychotic medications as per physician orders including those orders written for gradual dose reductions. Licensed Nurses will be educated by Director of Nursing/designee will be		4/26/22
	Resident #6 was re-a	dmitted to the facility on			Director of Nursing/designee will be		

Event ID:9UBI11

Facility ID: 932930

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/28/2022 M APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING				C / 31/2022	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	E HEALTH CARE CENT	FR		19	987 HILTON ROAD			
	JE NEAEIN GARE GERT			В	SURLINGTON, NC 27217			
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 658	Continued From page	e 14	F	658				
	1/14/21with diagnose with behavioral distur 6's recent Annual Mir assessment, dated 1/ Resident #6 was cog antipsychotic medica Record review reveal Practitioner (NP #1) v indicated that Reside for a gradual dose re- purpose, on 2/3/22, re (antipsychotic medica from 10 milligrams (m A review of the physic revealed: an order da discontinue Zyprexa start Zyprexa 5 mg by dose reduction (GDR A review of the Medic (MAR) for Resident # revealed on 2/3/22 th Zyprexa 10 mg was of the new order for Zyp transcribed to the MA was not administered Record review of the 2/4/22 - 2/16/22 revea Resident #6 ' s conditioned	es that included dementia bance. A review of Resident imum Data Set (MDS) /11/22, revealed that nitively intact. She received tion. led the Psychiatric Nurse visit note dated 2/3/22 nt #6 had clinical indications duction (GDR) trial. For this educe Zyprexa ation) by mouth at bedtime ng) to 5 mg. cian's order for Resident #6 the dated 2/3/22 to 10 mg by mouth daily and y mouth daily for gradual .). cation Administration Record 6 for February 2022 e order to discontinue completed as ordered, but			education on transcription of physicia orders including those orders written gradual dose reductions. Licensed Nurses/outside agency stat new hires who are not educated will r be allowed to work until education received. Director of Nursing or designee will at all gradual dose reductions of antipsychotic medications done 5x we x 4 weeks, then weekly x 8 weeks, the monthly x 3 Results of all audits will be reviewed a Quarterly Quality Assurance Meeting for further resolution if needed. Completion Date: 04/26/2022	for ff/ hot udit eekly en at		
	reaction to abrupt dru On 3/28/22 at 1:55 Pl Unit Manager indicate							

Facility ID: 932930

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345420	B. WING				C 31/2022
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 658	from 10 mg to 5 mg. who received the new of Zyprexa and did no for 5 mg. As a result, Zyprexa until the resid staff on 2/16/22, and From 2/4/22 to 2/15/2 receiving other psych not show withdrawal s Record review reveal 2/17/22, indicated a p conducted with Resid explained the purpose that the order for Zypr correctly. As a result, Zyprexa for twelve da On 3/28/22 at 11:25 A Director of Nursing (D February 2022, for Re #1 discontinued 10 m mg of Zyprexa. Nurse MAR the order to disc but did not transcribe Zyprexa on 2/3/22. D left the facility and wa interview. On 3/29/22 at 12:00 F interview, Medical Dir follow the physician's the MAR on time. On 3/28/22 at 3:30 PI interview, NP #1 indic ordered on 2/3/22 for changed the order for	The floor nurse (Nurse #11) v order, discontinued 10 mg of transcribe the new order Resident #6 did not receive dent's family called nursing the situation was corrected. 22, the resident continued otropic medications and did symptoms. ed NP #1's visit note, dated whone conversation was lent #6's family. NP #1 e of a GDR and apologized rexa was not transcribed the resident did not receive rys. AM during an interview the DON) indicated that in esident #6 's GDR trial, NP ng of Zyprexa and ordered 5 e #11 documented in the continue 10 mg of Zyprexa the new order for 5 mg ON stated that Nurse #11 as not available for an PM, during the phone rector expected the staff to order and transcribe it to M, during the phone cated that a GDR trial was	F	65			

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED				
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING	3	C		
		345420	B. WING		03/31/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
	CE HEALTH CARE CEN	TER		1987 HILTON ROAD			
				BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 658	Continued From pag	e 16	F 65	58			
		rexa was discontinued on the					
	MAR, and Resident	#6 did not receive it from					
	2/4/22 to 2/15/22. Or						
		ation order error, and NP #1 nt's family with an apology for					
		stated that the resident did					
		syndrome because she					
	received other scheo						
F 684	psychotropic medica	tions.	F 68	24	4/26/22		
F 664 SS=H			FOC	04	4/20/22		
	§ 483.25 Quality of c						
		undamental principle that					
		ent and care provided to sed on the comprehensive					
		ident, the facility must ensure					
		e treatment and care in					
		fessional standards of					
		hensive person-centered					
	care plan, and the re	T is not met as evidenced					
	by:						
		view and staff, Nurse		F684			
		dical Director interviews, the		Resident # 7 is no longer a	resident in the		
	facility failed to comp	nete full body skin ing resident's genitalia, back		facility Current residents will have	complete skin		
		of 8 sampled residents		observation completed by r			
	-	13/22, Resident #7 was sent		leadership team to include			
		partment (ED) for evaluation		genitalia and lower legs. Sk			
		ndicated the Resident had f his scrotum and groin,		observations will be comple 04/26/2022	ed by		
		to his foreskin with active		Licensed nurses will be edu	ucated by		
	-	pressure ulcers and multiple		DON/designee on performing	ng thorough		
		ver the body. In addition, an		skin assessments weekly w			
		D) band was imbedded in his artially lifted when they		documentation in the medic skin assessment will be cor			
	L Dack and a toenall b	amany meo when hev	1	SKID ASSESSMENT WIII DE CON			

Facility ID: 932930

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING			C 03/31/2022		
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
ALAMANO	E HEALTH CARE CENT	ER			87 HILTON ROAD IRLINGTON, NC 27217			
(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 684	assessment, dated 3/ cognition. Resident # hereditary spastic par legs and lower body), of the urinary bladder adjustment of urinary disorder, and fungal for received extensive as always incontinent for used a condom (exter rejection of care 1 to 3 back, and received par psychotherapy. Review of Resident # 3/6/22, revealed that of major depression, he behavioral symptoms refusing medications interventions were to ordered, monitor, and and effectiveness. Review of the physicia March 2022 for Resid to complete a weekly Friday's day shift and to apply condom cath validate anchor for the every shift, change it	inited to the facility on e Minimum Data Set (MDS) 13/22, revealed intact 7's diagnoses included aplegia (paralysis of the neuromuscular dysfunction , encounter for fitting and device, major depressive eet infection. The resident asistance with ADL, was bowel and bladder, and rnal) catheter. He exhibited 3 days during the 7-day look sychotropic medications and 7's plan of care, dated due to his diagnosis of exhibited adverse : resistive to care, agitation, and treatment. The administer medications as document for side effects an's orders for February - ent #7 revealed the orders: skin assessment every document it; eter, provide catheter care, e catheter and privacy bag as needed; to apply the the morning and remove it	F 64	84	hospital prior to the transfer. Any Licensed Nurse/outside agency staff/new hires who is not educated will not be allowed to work until education received. DON or designee will audit skin observations to ensure completeness of skin observation and timeliness of skin observation 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x Results of the audits will be reviewed a Quarterly Quality Assurance Meeting X for further if needed. Completion April 26, 2022	of 3 t		
	compression hose in at noon.	the morning and remove it						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345420	B. WING				31/2022	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 684	Resident #7 revealed skin assessment, data conducted the assess resident's skin was in On 3/28/22 at 11:50 A Nurse #12 indicated t she was assigned to the skin assessment. the same offer twice of same result. Nurse #7 physician she did not assessment due to th On 3/29/22 at 7:10 Al Nurse #5 indicated th assessments very oft the hospital on 3/13/2 completed his full boo 3/4/22, and did not fir Review of the care tra revealed that on 3/2/2 3/11/22, nurse aides of skin without new skin Review of the nurses' 4:32 AM, revealed tha of the abdominal pain resident ' s penis and swollen, and purple u catheter drainage bag the physician on call. the hospital evaluatio refused when the Em (EMS) team arrived. A	his last documented full ed 3/4/22. Nurse #5, who sment, documented the tact. AM, during an interview, hat on first shift of 3/11/22, Resident #7 and he refused The nurse came back with during her shift with the 12 did not notify the complete the skin e resident's refusal. M, during an interview, at Resident #7 refused skin en. Before his discharge to 12, the last time Nurse #5 dy assessment was on ad skin issues. acker for March 2022 22, 3/3/22, 3/8/22, and observed Resident #7 ' s conditions. Thotes, dated 3/13/22 at at Resident #7 complained burgen assessment, the scrotum were purple and rine was observed in the g. Nurse #7 reported this to She received an order for	F	684				

Facility ID: 932930

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING				C /31/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 684	Nurse #7 was not ava Hospital records revie Resident #7 arrived a Department (ED) with scrotum and groin, ar extensively taped with assessment in ED de lesions to his foreskin multiple skin discolora ulcers and abrasions ED found an ID (ident in his back skin and d compression hose a t the nail bed. On 3/28/22 at 2:15 PI Director of Nursing (I assessments to be do the physician. She wa assessments not beir or in full due to Resid behavior. The DON c #7's skin assessment through when he was DON confirmed that t armbands. She did no "could get the armbar hospital nurses descr On 3/28/22 at 3:40 PI interview, Psychiatric indicated that Reside and made his own de that he refused care, The NP #1 stated she	ailable for interview. ew revealed that on 3/13/22, t the Emergency a significant swelling of his and his condom catheter was a medical tape. The skin scribed multiple excoriated with active bleeding, ations, two sacral pressure over the body. The staff in tification) band "embedded" luring removal of to enail partially lifted from M, during an interview, DON) expected weekly skin one weekly as ordered by as aware of skin ng completed per schedule ent #7's resistance to care ould not provide Resident documentation after 3/4/22 discharged on 3/13/22. The he facility did not utilize the ot know how the resident ad embedded in his back" as ibed. M, during the phone Nurse Practitioner (NP #1), nt #7 was cognitively intact cisions. NP #1 was aware including skin assessments. a had adjusted the resident's ion regimen with limited and	F	684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345420	B. WING				C 31/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
ALAMAN	CE HEALTH CARE CENT	ER			987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 684 F 690 SS=H	On 3/29/22 at 12:00 F Corporate Nurse Con Resident #7's skin as documentation should weekly and as needer On 3/29/22 at 12:00 F interview, the Medical aware of Resident #7 Medical Director furth not forcefully push ale residents "to do or no dangerous for himself further revealed staff resident about possib non-compliance and p evaluation and treatm Bowel/Bladder Incont CFR(s): 483.25(e)(1)- §483.25(e) Incontiner §483.25(e)(1) The fac resident who is contin admission receives se maintain continence u condition is or becom not possible to mainta §483.25(e)(2)For a re incontinence, based of comprehensive asses ensure that- (i) A resident who ent indwelling catheter is resident's clinical con- catheterization was n (ii) A resident who ent	PM, during an interview, the sultant indicated that sessment and d have been completed d. PM, during a phone I Director stated he was 's behavior issues. The er stated that the staff could erf/oriented, cognitively intact t to do tasks" until it became f or others. The interview continued to educate the le negative outcomes of his provide psychiatric tent with monitoring. inence, Catheter, UTI -(3) the er such that continence is as the facility without an not catheterized unless the dition demonstrates that		684			4/26/22

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/28/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED	
		345420	B. WING		C 03/31/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
ALAMANO	CE HEALTH CARE CENT	ER		987 HILTON ROAD BURLINGTON, NC 27217	
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 690	as possible unless the demonstrates that ca and (iii) A resident who is receives appropriate prevent urinary tract if continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by: Based on the record Practitioner, and Med facility failed to mana catheter; the facility he was applying a condor without a physician's tape around the cond failed to consider alter resident's urinary incor- reviewed for urinary of 3/13/22 Resident #7 Department (ED) with scrotum and groin an extensively taped with catheter was remover to concerns for comp- penis and scrotal area	val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nfections and to restore ent possible. esident with fecal on the resident's assment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as to not met as evidenced review, staff, Nurse lical Director interviews, the ge the care for a condom ad knowledge the resident om catheter independently order, and wrapping medical iom catheter; the facility renative interventions for the portinence for 1 of 2 residents catheters (Resident # 7). On arrived at the Emergency in significant swelling of his d his condom catheter was in medical tape. The condom d immediately on arrival due romised circulation to the a. Blood was observed	F 690	F690 Resident # 7 is no longer at the facility Current residents with condom cathet will be audited by DON/designee for appropriate orders and appropriate ca orders. Alternative interventions will b provided if condom catheter is not appropriate Clinical staff will be educated by DON designee on care of condom catheters and alternative interventions to condou catheters. Any Licensed Nurse who is not educa will not be allowed to work until educa received Any new Licensed Nurses will be educated by Staff Development Nurse	ers re e / / s m ted tion or
	removed. The skin a multiple excoriated le	s when the catheter was ssessment in ED described sions to his foreskin with dent #7 was admitted due to		Director of Nursing or designee during orientation process DON or designee will audit all condom catheters for orders and alternative	

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	FED: 04/28/2022 RM APPROVED NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING _			C 03/31/2022		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ΔΙΔΜΔΝΟ	E HEALTH CARE CENT	FR		19	987 HILTON ROAD			
				В	URLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 690	Continued From page	e 22	F	590				
	suspected septic sho				interventions if needed 5x weekly x 4			
					weeks, then weekly x 8 weeks, and the			
	Findings included:				monthly x 3 Results of the audits will be reviewed	at		
	Record review revealed the facility's policy,				Quarterly Quality Assurance Meeting			
		re and Catheterization,"			for further resolution if needed.			
		ted for licensed nurses the						
		tion of the condom catheter			Completion April 26, 2022			
	nurse should assess	e standard of practice. The						
		g and signs of impaired						
	circulation several tin							
		ress notes the date/time of						
		e catheter, skin and penis						
	-	external catheter application, , and urine appearance and						
	amount.	, and anne appearance and						
		nitted to the facility on						
	· · ·	/ Minimum Data Set (MDS)						
		2/4/21, revealed his intact						
	-	7's diagnoses included raplegia (paralysis of the						
		, neuromuscular dysfunction						
	of the urinary bladde	r, encounter for fitting and						
	adjustment of urinary							
		The MDS indicated the						
	resident required extended activities of daily livin	ensive assistance with g (ADL), was always						
		and bladder, and used a						
	condom (external) ca							
		3 days during the 7-day look						
	-	sychotropic medications and						
	psychotherapy.							
		sident #7's plan of care,						
		ed that he had a condom						
	· ·	d his condom catheter, and regardless of education "that						
L								

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		345420	B. WING				C 31/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 690	this is not appropriate interventions were to catheter per the physic condom catheter bag of the bladder, and m discomfort in urination due to the catheter. T indicated that the resis behavioral symptoms interventions were to ordered, monitor, and and effectiveness. Review of the physici- dated 12/3/21, reveal condom catheter, pro the anchor for the cat shift, and change it as Records review revea- the Director of Nursin indicate that DON "ec- regarding the risks an continuous refusal of actions witnessed witt catheter and serious of including death." Res die." Records review of the 2/16/22, revealed that put his condom cathe off. Nurse #12 applied the resident requester penis. The Nurse #12 the hazard in using ta serious skin issues, a	and can lead to injury." The change the condom ician's order, position the and tubing below the level onitor for signs of an and frequency and pain he same plan of care dent exhibited adverse as resistive to care. The administer medications as document for side effects an's orders for Resident #7, ed the orders to apply vide catheter care, validate heter and privacy bag every s needed. and the written statement of g (DON), dated 2/15/22, lucated Resident #7 ad consequences of care and inappropriate h regard to taped condom danger of this action up to ident #7 replied "If I die, I	F	69			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING			C 03/31/2022	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANO	CE HEALTH CARE CENT	ER			987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 690	Social Worker (SW) v often did not allow the catheter. SW rememb resident asked her for to the condom. SW re- employed experience application, according SW mentioned that us to "bad and scary cor verbalized that SW "p not like anyone but hi The SW notified the fit the name). On 3/29/22 at 9:00 AI interview, Nurse #8 in refused condom cathe- very often and prefern himself. On 3/9/22, he tape around the cond to remove it, the resid confused, and request tape. The nurse reorid reminded him that he the condom himself. sleep and did not allo tape from his condom know where the resid There was no edema resident's genitalia no did not notify the nurse because it was well k routine behavior. Review of the nurses 4:32 AM, revealed that of the abdominal pain	M, during an interview, vas aware that Resident #7 e staff to apply condom bered in February 2022, the r tape, which he would apply eplied that the facility d staff for condom catheter g to the standard of care. sing the tape could lead him isequences." Resident #7 robably right", but he "does m touching his catheter." door nurse (could not recall M, during the phone idicated that Resident #7 eter application and care red to complete this task e was observed with white om. When the nurse asked lent became agitated, sted to have more white ented him to the place and had placed the tape around The resident fell back to w Nurse #8 to remove the a catheter. Nurse #8 did not ent received the white tape.	F	690			

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	FORM APPROVED OMB NO. 0938-0391							
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		345420	B. WING				31/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMAN	CE HEALTH CARE CENT	ER		1987 HILTON ROAD BURLINGTON, NC 27217				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE	
F 690	purple urine in the cal presented symptoms Nurse #7 reported it t received an order for which resident refuse medical Service (EMS additional conversation floor staff, the resider hospital. The Nurse #7, who w on 3/13/22, was not a On 3/28/22 at 1:45 Pf Nurse #6, Unit Manage reported that Resider condom catheter app assessment of his pri manipulated with whit The staff educated th poor outcomes, but h behavior. Nurse #6 re Nursing (DON) and N times. On 3/13/22, Nur resident complained of assessment, his genit and purple. Nurse #7 physician on call and the resident to the ho Record review of the revealed the team ob a condom catheter th his penis with medica also noted to be enlar the drainage bag was	theter drainage bag and of upper abdominal pain. o the physician on call. She the hospital evaluation, d when the Emergency S) team arrived. After on with the EMS team and at agreed to go to the as assigned for Resident #7 revailable for interview. M, during an interview, ger, indicated the nurses at #7 refused assistance with lication and skin vate area, and constantly te tape around the condom. e resident about possible e continued the same eported it to the Director of lurse Practitioners several urse #7 reported that the of abdominal pain. Upon talia were enlarged, swollen, communicated this to the obtained an order to send spital. EMS report, dated 3/13/22, served Resident #7 to have at was taped extensively to I tape. His scrotum was rged and tight. The urine in a purple.	F	690				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345420	B. WING			C 03/31/2022	
NAME OF P	ROVIDER OR SUPPLIER	-		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANCE HEALTH CARE CENTER					1987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	scrotum and groin and extensively taped with purple colored urine in assessment in ED de lesions to his foreskin also noted the condor immediately on arrival compromised circulat area. Blood was obset when the catheter wa was admitted due to s Records review reveat the Administrator, dat Nurse #7, assigned fo 3/13/22, reported she private area was red/p urple urine in the dra Emergency Medical S refused to go to the h conversation, EMS te Emergency Departmet On 3/28/22 at 3:40 PP interview, Psychiatric indicated that Resider and made his own de that he refused care, care. NP #1 indicated medication regimen w temporary effects on 1 On 3/29/22 at 7:10 All Nurse #5 indicated th the staff to provide ov	a significant swelling of his d his condom catheter was a medical tape. There was in the drainage bag. The skin scribed multiple excoriated with active bleeding. It was m catheter was removed I due to concerns for ion to the penis and scrotal erved coming from his penis s removed. Resident #7 suspected septic shock. aled the written statement of ed 3/28/22, indicated that or the Resident #7 on assessed the resident: his purple and swollen with ainage bag. Nurse #7 called Service (EMS). The resident ospital, but after additional am took the resident to the ent (ED). M, during the phone Nurse Practitioner (NP #1) int #7 was cognitively intact cisions. NP #1 was aware including condom catheter I the resident's psychotropic vas adjusted with limited and his behavior. M, during an interview, at Resident #7 did not allow rerall condom catheter care white tape around his	F	690			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING				C 31/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
ALAMANO	LAMANCE HEALTH CARE CENTER			1987 HILTON ROAD BURLINGTON, NC 27217				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Nurse #12, indicated comply with condom of care. He constantly m catheter, did not allow catheter care, used w condom, and rejected The Nurses #12 did m notes each time she of resident's condom cat NP or Medical Directo applied the tape on hi On 3/30/22 at 8:40 Af interview, Nurse Aide #7 often applied the w condom and did not w Aide #7 did not know the tape and observer resident's room. Nurse tape on the condom cat provided the condom cat did not notify the nurse on the condom cat did not notify the nurse on the condom cat heter. He did not resident #7 with tape catheter. He did not resident received the condom catheter. Nur she reported it to the come to talk to the res	M, during an interview, that Resident #7 did not catheter application and nanipulated his condom withe staff to provide white tape around the the genitalia skin check. Not document in the nurses observed the tape around theter. She did not notify the or every time the resident is condom catheter. M, during the phone #7 indicated that Resident white tape around the vant to remove it. Nurse how the resident received d the roll of tape in the e Aide #7 did not touch the catheter because nurses catheter application, oval procedures. The wn for tape application atheter, so Nurse Aide #7 ses when he observed tape ter. M, during an interview, ed that she often observed e around his condom allow the staff to remove it. t know where and how the tape, he used for his rse Aide #8 stated at times floor nurses, who would	F	690				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	0. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345420 B. WI				03	C 3/31/2022	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX i	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 690	DON stated she was not in compliance with application and care. applied tape around t remove it. The staff d resident. The DON st it online and had it de Resident's behavior, I continuous refusal of witnessed with regard with possible serious discussed with NP #1 2/2/22 and 2/24/22, d adjusted the psychotr without significant cha behavior. When Nurs with swollen genitalia drainage bag, she set the physician's order. On 3/29/22 at 12:00 F interview, Medical Dir #7's behavior issues, physician's orders for Director stated that the push alert/oriented, ca do or not to do tasks" for himself or others. mentioned he did not discussed his situatio that, the Medical Dire resident's family, but Resident #7 was estra had no support. There psychotropic treatment	aware that Resident #7 was in condom catheter The staff reported he he condom and refused to id not provide the tape to the ated most likely, he ordered livered to the facility. The risks, and consequences of care, inappropriate actions d to taped condom catheter, danger of this action, was and Medical Director. On uring the visits, NP #1 opic medication regimen anges in the resident e #7 assessed the resident and purple urine in the in the resident to the ED per PM, during the phone rector was aware of Resident including not following the a condom catheter. Medical the staff could not forcefully ognitively intact residents "to until it becomes dangerous The Medical Director visit the Resident #7 but n with NP#1. In the case like ctor would contact the	F	690				

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