DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		LETED
		345381	B. WING			C 09/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	09/2022
				140 INGRAM ROAD		
VILLAGE	CARE OF KING			KING, NC 27021		
(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)		(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	conducted on 08/03/2 The facility was found §483.73 related to E-	ents for Long Term Care 5WKZ11	F 000			
	Control Survey and c conducted on 08/03/2 The facility was found §483.80 infection con implemented the CMS Control and Preventio	VID-19 Focused Infection omplaint investigation were 2022 through 08/09/2022. I in compliance with 42 CFR trol regulations and has S and Centers for Disease on (CDC) recommended or COVID-19. Event ID#				
		89385, NC00190276				
	Immediate Jeopardy	was identified at:				
		84 at a scope and severity J 89 at a scope and severity J				
	The tags F684 and F Quality of Care.	689 constituted Substandard				
		began on 6/01/2022 and i/2022. A partial extended d.				
F 684	Quality of Care		F 684			8/10/22
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE
Electroni	cally Signed					09/02/2022

**Electronically Signed** 

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/07/2022

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345381	B. WING _			C 08/09/2022		
NAME OF P	AME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
VILLAGE	CARE OF KING				0 INGRAM ROAD NG, NC 27021			
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 684 SS=J	CFR(s): 483.25 § 483.25 Quality of car Quality of care is a fu applies to all treatment facility residents. Bas assessment of a resident that residents received accordance with profe- practice, the compret- care plan, and the residents received accordance with profe- practice, the compret- care plan, and the resident pro- the REQUIREMENT by: Based on record rever- physician interview the nurse assess one (Re- residents reviewed for Resident #1 had her the bed and the sit to the shower chair. Bef- the nurse, Resident # shower chair, received transferred back to be pain and was transfer- she expired from com- right calf hematoma. Immediate Jeopardy Nurse aide (NA #8) w and pinched her leg to to stand lift causing p- the nurse of the injury transferred with the s- shower chair, given a transferred onto the to The immediate jeopa	are ndamental principle that in and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of hensive person-centered sidents' choices. T is not met as evidenced iew, staff interviews, and he facility failed to have a esident #1) of three ir assessment after injury. right leg pinched between stand lift during a transfer to fore reporting the injury to ef was transferred to a d a shower, and was ed. Resident #1 experienced rred to the hospital where hplications with a traumatic began on 6/1/2022 when vas transferring Resident #1 between the bed and the sit ain. Prior to notification of <i>y</i> , Resident #1 was it to stand lift onto the shower, and then bed without the use of a lift. rdy was removed on	F	584	<ol> <li>Corrective action for affected Resident #1 is no longer in the facility</li> <li>How will facility identify other like residents:         <ul> <li>A 30-day lookback of incidents to ident any where a lift was involved was completed. There were no incidents involving lifts noted. This was completed on 8/6/2022.</li> <li>Specify the action the facility will tak to alter the proces or system failure to prevent a serious adverse outcome fro occurring or recurring, and when the action will be complete.</li> <li>Current nursing staff was reeducated concerning when to notify the nurse prito moving a resident when there is any</li> </ul> </li> </ol>	ify ed ce m		
		cility implemented an Ilegation for Immediate ne facility remains out of			change of condition. Changes include any change of condition whether media changes (including physical			

Facility ID: 923523

		MEDICAID SERVICES				38-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
					с	
		345381	B. WING	08/09/2	2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
VILLAGE	CARE OF KING		440 INGRAM ROAD KING, NC 27021			
	CUMMADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE CC	(X5) MPLETIO DATE
F 684	Continued From page	e 2	F 68	84		
	-	r scope and severity level of		changes of condition suc	ch as changes in	
		with the potential for more		breathing, ability to move		
	than minimal harm th			vital sign changes, verba	al or nonverbal	
	jeopardy) to ensure n education put into pla	nonitoring systems and ace are effective.		signs of pain), mental ch	anges	
	p			(including change in leve	el of	
	Findings included:			consciousness, behavio		
				increased		
.   .		nitted to the facility on		confusion)or if there has		
		itative services. Resident #1		or accident involving the		
	Type 2 Diabetes Mell	es some of which included		staff must get a nurse to resident prior to moving		
	thrombocytopenia, ar					
				Specific focus during the		
		e quarterly Minimum Data		be that any time a reside	-	
		d 5/31/2022 did not assess ognition. Resident #1 was		pain, whether verbally of during a transfer, the tra		
		ly impaired hearing and		stopped, and the resider		
		as able to be understood		nurse before the any fur		
		rs. Resident #1 was coded		the resident.		
	on the same assessn	nent as being able to		At any time there is a ne	ed for	
	transfer with the exte	nsive assistance of one		assessment by a nurse,	the staff member	
		ing steady with surface to		must stay		
		sident #1 was coded as		with the resident, put the		
		on impairment on both sides es. In addition, Resident #1		yell out to get assistance	÷.	
		ng an anticoagulant on 7				
	days of the assessme			The reeducation was pro	ovided by the	
		,		Director of Nursing, the	-	
	Documentation on the	e care plan, last revised on		of		
		a focus area for a self-care		Nursing, Unit Managers,		
		1 relative to weakness, pain,		had been reeducated on	the process.	
		ral knees with decreased		This was a late to a	0,0000	
	trange of motion. One transfer Resident #1	of the interventions was to with one staff assist		This was completed by 8	5/8/2022.	
		שונה טווב סומו מסטוסו.		Agency nursing staff and	newly hired	
	Documentation on the	e same care plan was a		nursing staff will have th	-	
		on 2/3/2022, for Resident		-	r orientation.	
	-	lant therapy. Interventions				

Facility ID: 923523

			0.00				D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		SURVEY PLETED
		345381	B. WING		C 08/09/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			09/2022
					IO INGRAM ROAD		
VILLAGE	CARE OF KING			ĸ	ING, NC 27021		
(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 APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 3	F 68	84			
	included administratio		1.00		4. How will compliance be maintained		
		of activities that may cause			and monitored		
		g of signs and symptoms of			Beginning the week of 8/8/2022 the		
	bleeding.				Director of Nursing and/ or designee w	ill	
					monitor 5 residents per week for 12		
		ohysician's progress note for by MD #1 dated 4/13/2022			weeks to ensure that any change of condition had appropriate notification a	nd	
		ssment and plan portion of			a timely nursing assessment complete		
		a - This appears to be a			Any negative findings will be addessed		
		cutaneous fat layer. The fat			immediately and the MD and RP wil be		
		or 2 days after it was first			made aware.		
	noted suggested that	-			5. QAPI		
	-	aps there is some venous			This plan was reviewed in a QAPI mee	ting	
		area that makes her prone to relto for stroke prevention. I			on 8/10/2022. The Director of Therapy and the Direct	or	
		put a dressing on it that			of Nursing will report the results	01	
		re, stop her Xarelto for 24			······································		
		ed at a reduced dose that			of monitoring to the QAPI committee for	or	
		then heal. I am afraid that if			review and recommendations for the ti		
	we stop it for too long	-			frame of the monitoring period or as it i	S	
		gulable and that this would			amended by the committee.		
	put her at risk for stro thrombosis]."	oke of [deep vein			The Director of Nursing, the Director of		
					Therapy, and/or designees are		
	Documentation in the	e physician orders dated as			responsible for		
		2 revealed Resident #1 was			the Corrective Action Plan Dated:		
		ns of Xarelto (blood thinner)			8/10/2022.		
	as one tablet given by atrial fibrillation.	y mouth one time a day for					
		e nursing notes written by					
		nt #1 revealed on 6/1/2022 in					
	-	PM stated, "This nurse was lent had a hematoma on					
		ssment done. Skin was intact					
		blister type of hematoma on					
		hin. Notified [Doctor] and					
	received orders to ap						
	Resident was intolera	ant of any touching of wound.					1

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	F DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:		G	· · · ·	IPLETED	
						С	
		345381	B. WING		08/09/2022		
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE			
				440 INGRAM ROAD			
VILLAGE	CARE OF KING			KING, NC 27021			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From page	≥ <b>∕</b>	F 68	84			
[As needed] pain [med Hematoma was approv 2 ½ inches in width and			FOC	94			
		10					
		• •					
		to increase in size and					
		complain. Now					
	approximately 45 mir	nutes later hematoma had					
		extend from the ankle and up					
		d expanded across [front] of					
		ximately 3-4 inches high.					
	Resident request to g						
		ders to transfer to hospital,					
	[family] notified, Adm						
	PM]."	al approximately [10:30					
	NA #8 was interviewe	ed on 8/4/2022 at 11:15 AM.					
	NA #8 revealed on 6/	1/2022 she went into the					
		at approximately 8:00 PM to					
	•	A #8 explained how she set					
	•	and positioned the resident					
		d with her feet on the lift. NA					
		lifted Resident #1 with the					
	sit to stand lift and tui	rned the lift toward the					
		hed between the bed and					
		sed pain, so she lowered					
	-	to the bed with the sit to					
		ated she asked Resident #1					
		hich Resident #1 replied she					
	was fine. NA #8 state	d she did not notify the					
		cause she thought the					
		red. NA #8 again transferred					
		bed to the shower chair					
		lift. NA #8 took Resident #1					
		n the shower chair and gave					
		noticed while she was in the					
		re was a bruise on the right					
		A #8 took Resident #1 back					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 09/07/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING_			_		C 09/2022
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				44	40 INGRAM ROAD			
VILLAGE	CARE OF KING			κ	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	into the bed and then NA #8 stated she did bad, so she went back shower. NA #4 was interviewe NA #4 revealed he was Resident #1 on the 3: #4 said he was doing the help of NA #10 on #1 resided on 6/1/202 did not ask NA #4 for #1 to the shower chai a resident room when asking for help transfe she had hit her leg. N the room of Resident size of the bump on h described it as, "really had not told the nurse point. NA #4 indicated sit to stand lift so, NA armed and pivoted" R #4 went to get Nurse # bed. Nurse #3 came i went to get pain medi because she was in a Nurse #3 was intervie PM. Nurse #3 stated a Resident #1 to the she she was coming back something was wrong approached her. Nurs room of Resident #1 a bed. Nurse #3 revealed the right leg of Resident	A #10 put Resident #1 back they went to get a nurse. not think the bruise was that k to work to give another d on 8/3/2022 at 3:45 PM. as assigned to care for 00 PM to 11:00 PM shift. NA incontinent care rounds with the hallway which Resident 2. NA #4 revealed NA #8 help in transferring Resident r. NA #4 indicated he was in the transferring Resident r. NA #8 came to the room erring Resident #1 because A #4 stated when he got to #1, he could not believe the er right leg. NA #4 v big." NA #4 stated NA #8 e about the injury at that d he did not want to use the #4 and NA #10 "strong tesident #1 into the bed. NA #3 after they got her in the n and saw the leg and then cation for Resident #1 l lot of pain. wed on 8/3/2022 at 4:24 she did not see NA #8 take ower. Nurse #3 revealed onto the hall and she knew	F	584				

	-	D HUMAN SERVICES					FORM	): 09/07/2022 MAPPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345381	B. WING			_		C 09/2022
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF KING			4	40 INGRAM ROAD			
VILLAGE	CARE OF KING			ĸ	KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	went to get pain medi NA #4, NA #10, and N Resident #1. Nurse #3 later, she gave the pa #1. Nurse #3 stated s overreacting and the P as it was going to get. Nurse #5, to help asse nurse practitioner. Nu know how Resident # but she assumed it has shower. Nurse #3 rev about Resident #1 be the incident to commu- practitioner. Nurse #5 was intervie PM. Nurse #5 stated s when Nurse #3 appro asked her to come loo of Resident #1. Nurse seem to her that anyb had occurred. Nurse # time, all she knew wa taken for a shower an bruise on her right leg to the room of Reside blood blister under the long on the right lowe below the calf, with 2 Nurse #5 explained how was contacted, contin staff, and ultimately R hospital.	a lot of pain. Nurse #3 cation for Resident #1 as IA #8 were in the room with 3 indicated, about 5 minutes in medication to Resident he thought Resident #1 was large hematoma was as big . Nurse #3 went to get ess the area and contact the rse #3 stated she did not 1 acquired the hematoma, appened prior her getting a ealed she was not thinking ing on Xarelto at the time of unicate this to the nurse wed on 8/4/2022 at 2:59 she was on another hallway ached her on 6/1/2022 and ok at a big bruise on the leg e #5 explained that it did not wody knew how the injury #5 explained that at the s that Resident #1 was id put back to bed with a p. Nurse #5 stated she went nt #1 and saw she had a e skin that was 3 to 4 inches r leg, above the ankle and inches rounded on top. ow the nurse practitioner ued monitoring by nursing tesident #1 was sent to the	F	684				
	hospital. An interview was cond Administrator on 8/4/2							

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/07/2022 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		345381	B. WING			08/	C 09/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				440 INGRAM ROAD			
VILLAGE	CARE OF KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Resident #1 was pinc the sit to stand lift why position the resident of Administrator stated s was not notified immediate leg of Resident #1 wat The Director of Nursin on 8/5/2022 at 11:17. was not in the position DON stated she woul aide to notify a nurse resident expressed ge be her expectation if a expresed pain, a nurse assessment. An interview was com- Director and physician on 8/4/2022 at 3:23 P made aware of Resid hospital for a pinched into a bruise and kept occurrence was very could not have had an hematoma would grou being sent to the hosp was. Documentation on the the hospital dated 6/1 history of present inju presented from skilled trauma to her right low development of very I arrived at the hospital significant blood loss provider." Documentation	hed between the bed and en NA #8 turned the lift to on the shower chair. The she was not aware Nurse #3 ediately by NA #8 when the as pinched. ng (DON) was interviewed AM. The DON revealed she n of DON on 6/1/2022. The d not have expected a nurse	F 68	34			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		345381	B. WING			08	/09/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	• • •	
VILLAGE	CARE OF KING				440 INGRAM ROAD KING, NC 27021		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	lower extremity. Ultim respiratory failure, he transitioned to Hospic 6/15/2022. Documentation on the Resident #1, dated as the immediate cause traumatic right calf he description of how the certificate stated, "tra while using lift to tran The Administrator wa jeopardy on 8/5/2022 The facility provided t allegation: F 684 o Identify those rec or are likely to suffer, as a result of the non Resident #1 was not during a transfer with then transferred seve NA #8 was transferrin stand lift to a shower shifted and was pinch lift. Resident #1 expres	d hematoma of her right hately Resident #1 had r left lung collapsed, ce care, and expired on e death certificate for s signed on 6/16/2022, listed of death as "complications ematoma." Under the e injury occurred the death umatic injury to right calf sfer patient." s notified of the immediate at 10:15 AM. the following credible cipients who have suffered, a serious adverse outcome compliance; assessed after an injury a sit to stand lift. She was tral times. ng Resident #1 with the sit to chair. Resident #1's right leg ned between the bed and the essed pain. sident #1 back to the bed	F	684			

Facility ID: 923523

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/07/2022 MAPPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING			_		C 09/2022
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VILLAGE	CARE OF KING				40 INGRAM ROAD			
				K	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684			F	684				
	nurse. NA #8 took Re and notified NA #4 an leg of Resident #1. N	sident #1 back to her room d NA #10 of an injury to the A #4 and NA #10 transferred shower chair to the bed						
		tified by NA #8 of an injury ident #1 for assessment.						
		day lookback of incidents to ft was involved.  There were lifts.						
	the process or system	n the entity will take to alter n failure to prevent a serious n occurring or recurring, and e complete.						
	moving a resident which condition. This will sp condition of a residen (including physical ch changes in breathing, vital sign changes, ve pain), mental changes of consciousness, bel increased confusion) incident or accident in staff must get a nurse to moving the residen	otify the nurse prior to en there is any change of becify any change of t whether medical changes anges of condition such as ability to move as before, rbal, or nonverbal signs of s (including change in level navioral changes, or or if there has been an ivolving the resident. The to assess the resident prior t.						
		the reeducation will be that presses pain, whether						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 09/07/2022 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_		C 09/2022
NAME OF P	ROVIDER OR SUPPLIER		S'	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			44	40 INGRAM ROAD			
VILLAGE	CARE OF KING		к	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	transfer must be stop assessed by a nurse movement of the reside At any time, there is a nurse, the staff member resident, put the call be assistance. This reeducation was Nursing, the Assistant Unit Manager on 8/5/2 nursing agency staff a For any nursing staff a members who were n facility on 8/5/2022, a reeducated will be assion oncoming shift to com before they take the r Director of Nursing has track the reeducation of all current nursing s staff. 8/6/2022 is the allege jeopardy removal. The credible allegatio as evidenced by: Surveyor was present evidence to removal of this visit, interviews w no issues. Interviews several staff from eac knowledge of the train education training. All education provided by	Ily, during a transfer, the ped, and the resident before the any further dent. a need for assessment by a per must stay with the pell on, and yell out to get provided by the Director of t Director of Nursing, or the 2022 for nursing staff and able to come to the facility. and nursing agency staff to table to come to the nurse that has been signed to meet each nplete the reeducation next assignment. The as begun and will continue to until completion of training staff and nursing agency d date of immediate n was validated on 8/9/2022 t on 08/09/22 to review the of the IJ for F 684. During rith alert residents indicated were conducted with th hall who revealed	F 684				

Facility ID: 923523

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		MEDICAID SERVICES		PLE CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		G	· · ·	MPLETED
						С
		345381	B. WING		08/09/202	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	CARE OF KING			440 INGRAM ROAD		
VILLAGE	CARE OF KING			KING, NC 27021		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pag	e 11	F 68	84		
	change in condition.					
		zards/Supervision/Devices	F 68	89		8/10/22
SS=J	CFR(s): 483.25(d)(1)	)(2)				
	§483.25(d) Accidents	8				
	The facility must ens					
		esident environment remains				
	as free of accident ha	azards as is possible; and				
		esident receives adequate stance devices to prevent				
	accidents.	stance devices to prevent				
		T is not met as evidenced				
	by:					
	Based on record rev	view, staff interviews, and a		1. Corrective action for affected	ed resident:	
	-	he facility failed to safely				
		to the shower chair one				
	,	e residents reviewed for		Resident #1 is no longer in the	facility	
	supervision during tra	d was transferred to the				
		expired from complications		2. How will the facility identify	other like	
	with a traumatic right			residents:		
	Immediate Jeopardv	began on 6/1/2022 when		All residents who require assis	tance with	
	Nurse aide (NA #8) t	ransferred Resident #1 from		transfers are at risk for this issu		
		er chair pinching her leg			<b>f</b> :	
		the sit to stand lift. NA #8 back down on the bed using		There was a 30-day lookback of completed on 8/6/2022 to iden		
		nen the resident expressed		where a lift was involved. The		
		sit to stand lift to transfer		incidents involving lifts.		
	Resident #1 to the sh	nower chair, gave her a		, v		
	shower, and returned	d her to her room. NA #4 and		The current in-house residents		
		nt #1 from the shower chair		reviewed and assessments we		
		-				
		-		completed 8/5/2022.		
	onto the bed without notifying the nurse of Resident #1. The imp removed on 8/6/2022	the use of a lift prior to f an injury to the leg of mediate jeopardy was		completed and assessments we completed to determine the con- residents' transfer status. The done by the Director of Rehabi- completed 8/5/2022.	rrect review v	

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TATEMENT (	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C 08/09/2022		
		345381	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER	•		S	IREET ADDRESS, CITY, STATE, ZIP CODE			
VILLAGE	CARE OF KING				40 INGRAM ROAD ING, NC 27021			
(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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	Immediate Jeopardy	removal. The facility	F	689				
	severity level of a "D'	•			Care plans were reviewed and all changes identified by the Director of Rehabilitation were updated in the residents' care plan by the nurses who perform Minimum Data S (MDS) assessments. The residents'			
	Findings included:	nitted to the facility on			transfer information was placed into the care plans in instructive language of the following transfer type stand and pivot with either an assist of	es:		
	1/14/2022 for rehabili	itative services. Resident #1 es some of which included litus, atrial fibrillation,			or assist of 2, sit to stand lift, or full lift The information was triggered to the Kardex for nursing staff that do not h access to the care plans. The number	nave		
	Documentation on th Set assessment date	e quarterly Minimum Data d 5/31/2022 did not assess cognition. Resident #1 was			staff required for the different types of is in the policy and training that the st have completed. This process was completed on 8/5/2022.	lifts		
	coded as having high impaired vision but w and understood othe	nly impaired hearing and vas able to be understood rs. Resident #1 was coded nent as being able to			<ol> <li>What will the facility do to prevent from recurring</li> </ol>	this		
	transfer with the exte person and as not be surface transfers. Re having range of motio	nsive assistance of one bing steady with surface to sident #1 was coded as on impairment on both sides			The facility reeducated nursing and therapy staff who assist with safe tran processes such as: stand and pivot transfers,			
	was coded as receivi days of the assessme				sit to stand lift process, and the full lift process. Reeducation of staff also included training on stopping transfers there were any difficulties and seek he	s if		
	3/14/2022, revealed a deficit for Resident # and stiffness in bilate	e care plan, last revised on a focus area for a self-care 1 relative to weakness, pain, eral knees with decreased			and nursing assessment once the resident is safe. If the resident had a noticeable decline prio the transfer that makes the current transfer status upage than that staff.	r to		
	transfer Resident #1 Documentation on th	of the interventions was to with one staff assist. e same care plan was a ent #1's use of anticoagulant			transfer status unsafe then that staff member will notify a nurse for assess and follow the nurses guidance to use total lift for			

Facility ID: 923523

## FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING \_\_\_\_ С 345381 B. WING 08/09/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 440 INGRAM ROAD VILLAGE CARE OF KING KING, NC 27021 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 689 Continued From page 13 F 689 therapy. Interventions included administration of any transfers unless changes by therapy medications as ordered and avoidance of after an evaluation. activities that may cause injury. This education was provided by the Director of Therapy, the Director of Documentation in a physician's progress note for Nursing, the Assistant Director of Nursing, Resident #1 written by MD #1 dated 4/13/2022 Unit Managers.and nurses who had been revealed in the assessment and plan portion of reeducated. This education was the note, "Hematoma - This appears to be a completed by 8/9/2022. hematoma in the subcutaneous fat layer. The fat it ruptured and bled for 2 days after it was first There was a return demonstration using noted suggested that she might be over the different transfer types used during anticoagulated. Perhaps there is some venous reeducation. The return demonstrations malformation in this area that makes her prone to were do this. She is on Xarelto for stroke prevention. I completed for all of nursing and therapy am hoping that if we put a dressing on it that staff by 8/9/2022. applies some pressure, stop her Xarelto for 24 hours, and then started at a reduced dose that The updated transfer status is found in the the leak will clot and then heal. I am afraid that if care plan or Kardex that is accessible by nursing staff and therapists. The updated we stop it for too long, she may become transiently hypercoagulable and that this would put her at risk for stroke or [deep vein transfer status for residents was done by thrombosis]." the Director of Rehabilitation and completed 8/5/2022. Documentation in the physician orders dated as initiated on 4/14/2022 revealed Resident #1 was Agency nursing staff and new hire nursing receiving 10 milligrams of Xarelto (anticoagulant) staff will receive this education as part of as one tablet given by mouth one time a day for their orientation. atrial fibrillation. 4. How will the Facility Monitor and Documentation in the nursing notes for Resident maintain ongoing compliance #1 revealed on 6/1/2022 in a late entry for 9:00 PM stated. "This nurse was notified that this resident had a hematoma on right lower leg. The Director of Therapy and/or designee Assessment done. Skin was intact but there was started observing transfers 5 times a a large blister type of hematoma on lower lateral week starting the week of 8/8/2022 to side of shin. Notified [Doctor] and received orders validate that the education process was to apply Betadine to area. Resident was intolerant effective. This included knowing the of any touching of wound. [As needed] pain transfer status of the residents', no [medication] given on request. Hematoma was concerns

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · ·	IPLETED
						С
		345381	B. WING		0	8/09/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				440 INGRAM ROAD		
VILLAGE	CARE OF KING			KING, NC 27021		
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From page	a 1 <i>1</i>	F 68	0		
1 000		ch in length, 2 $\frac{1}{2}$ inches in	F 00	-	ty to	
		high. Hematoma continued		with the transfers, and the abilition communicate that an assessme		
		Ingrit. Hematorna continued		nurse will be completed if there	•	
		eximately 45 minutes later		incident prior to transfer. This w		
		ased in size to extend from		documented for 12 weeks.		
		ottom of knee and expanded				
		of leg, and approximately 3-4				
	inches high. Residen	t request to go to hospital,		5. QAPI		
	notified [Doctor], rece	eived orders to transfer to				
	hospital, [family] notif	fied, Administrator notified,		This plan was reviewed in facili	ity QAPI	
		al approximately [10:30		meeting on 8/10/2022.		
	PM]."					
	NA #8 was interviewe	ed on 8/4/2022 at 11:15 AM.		The Director of Therapy and the	e Director	
		knew Resident #1 well and		of Nursing will report the result		
		reviously with a sit to stand		monitoring to the QAPI commit		
	lift quite a few times.			review and recommendations f		
	following events of 6/	1/2022. NA #8 stated she		frame of the monitoring period	or as it is	
	arrived on the hall Re	esident #1 resided at		amended by the committee.		
	approximately 8:00 P	M and went to her room to		-		
	prepare Resident #1	for a shower. Resident #1				
		ower. NA #8 set up the sit to		The Director of Nursing, the Director of Nursing, the Director of Nursing, the Director Director of Nursing, the Director Directo	rector of	
	stand lift and position	ed the resident on the side		Therapy, and/or designees are		
	of the bed with her fe	et on the lift. NA #8 stated		responsible for		
		ident #1 with the sit to stand		the Corrective Action Plan Date	ed:	
		toward the shower chair the		8/10/2022.		
		lipped and was pinched				
		the lift. Resident #1 cried				
		IA #8 lowered Resident #1				
		th the sit to stand lift. NA #8				
		she was okay to which she				
		fine. NA #8 again transferred bed to the shower chair				
		lift. NA #8 took Resident #1				
	-	n the shower chair and gave				
		noticed while she was in the				
		ere was a bruise on the right				
		IA #8 took Resident #1 back				
	to her room and requ					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	): 09/07/2022 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_	08/0	) 09/2022
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF KING		44	40 INGRAM ROAD			
VILLAGE			ĸ	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	into the bed by lifting then they went to get did not think the bruiss back to work to give a NA #4 was interviewe NA #4 revealed he was Resident #1 on the 3: 6/1/2022. NA #4 expla- bed bound resident w out of the bed. NA #4 events as occurring o was doing incontinent of NA #10 on the hally resided. NA #8 did no transferring Resident When NA #4 and NA they needed to provid came to the room and Resident #1 because stated when he got to he could not believe the leg. NA #4 described not want to use the sit NA #10 "strong armed into the bed. NA #4 w they got her in the bed saw the leg and then for Resident #1 because stated when for the pain in he kept checking on F an hour the area increa up to her knee.	A #10 put Resident #1 back her up under the arms and a nurse. NA #8 stated she e was that bad, so she went nother shower. d on 8/3/2022 at 3:45 PM. Is assigned to care for 00 PM to 11:00 PM shift on ained Resident #1 was a ho he had never transferred described the following n 6/1/2022. NA #4 said he care rounds with the help way which Resident #1 t ask NA #4 for help in #1 to the shower chair. #10 were on the last person e incontinent care, NA #8 asked for help transferring she had hit her leg. NA #4 the room of Resident #1, he size of the bump on her it as, "really big." NA #4 did to stand lift so, NA #4 and I and pivoted" Resident #1 ent to get Nurse #3 after d. Nurse #3 came in and went to get pain medication ise she was in a lot of pain. IA #8 attempted to get ole in the bed while Nurse hedication. NA #4 revealed Resident #1 but within half eased from around her ankle	F 689				
		wed on 8/3/2022 at 4:24 ed the following events as					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 09/07/2022 MAPPROVED ). 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345381	B. WING			_		C 09/2022
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	_	
	CARE OF KING			4	40 INGRAM ROAD			
VILLAGE				K	(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	#8 take Resident #1 to revealed she was con- she knew something w #4 approached her. N the room of Resident the bed. Nurse #3 rev on the right leg of Resident touch the hematoma a Nurse #3 went to get Resident #1 as NA #4 in the room with Resident minutes later, gave th Resident #1. Nurse #3 assist in the assessmenurse practitioner was was given to put Beta- ice. Nurse #3 went to approximately half an hematoma was increa- revealed she called th family of Resident #1, Services so, Resident but she assumed it has shower. Nurse #3 rev- about Resident #1 be the incident to commu- practitioner.	2. Nurse #3 did not see NA o the shower. Nurse #3 hing back onto the hall and was wrong as NA #8 and NA urse #3 stated she went to #1 and observed she was in ealed she saw a hematoma sident #8 that was the size at #1 did not want anyone to and was in a lot of pain. pain medication for , NA #10, and NA #8 were dent #1. Nurse #3, about 5 e pain medication to 8 went to get Nurse #5 to ent of Resident #1. The s contacted, and instruction dine on the hematoma and check on Resident #1 again hour later and realized the using in size. Nurse #3 is Nurse Practitioner, the and Emergency Medical #1 could be sent to the se #3 stated she did not 1 acquired the hematoma, uppened prior her getting a ealed she was not thinking ing on Xarelto at the time of unicate this to the nurse ysician's order initiated on tablet 5-325 milligrams (mg) ninophen) to be let by mouth every 12 hours	F	689				
	Documentation on the	e Controlled Medication						

AID SERVICES						APPROVED 0.0938-0391
OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:	. ,				(X3) DATE COMP	SURVEY LETED
345381	B. WING					) 09/2022
1		STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		440 INGRAM	M ROAD			
		KING, NC	27021			
OF DEFICIENCIES IE PRECEDED BY FULL TIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC ROSS-REFEREN	TIVE ACTION SHOULD BE CED TO THE APPROPRIA		(X5) COMPLETION DATE
ministration of n 5-325 mg (Norco) was administered 022 at 9:20 PM. n 8/4/2022 at 2:59 s on another hallway her on 6/1/2022 and big bruise on the leg plained that it did not ew how the injury ained that at the time ent #1 was taken for d with a bruise on d she went to the v she had a blood is 3 to 4 inches long the ankle and below ed on top. Nurse #5 dister was wrapped oped and Resident #1 . Nurse #5 revealed ut her leg hurting. ne Nurse Practitioner is advised to apply stated they did put e1 did not tolerate ice. minutes later Nurse her hallway again getting bigger on she saw at this point d in size up to the e knew she had to be 5 stated the Nurse gain and permission #1 to the hospital. with the Medical #1) for Resident #1	F 6	89				
	ATIFICATION NUMBER: 345381 OF DEFICIENCIES E PRECEDED BY FULL TIFYING INFORMATION) Ininistration of n 5-325 mg (Norco) was administered 022 at 9:20 PM. a 8/4/2022 at 2:59 s on another hallway her on 6/1/2022 and big bruise on the leg plained that it did not ew how the injury ained that at the time ent #1 was taken for d with a bruise on d she went to the v she had a blood s 3 to 4 inches long the ankle and below ed on top. Nurse #5 lister was wrapped oped and Resident #1 . Nurse #5 revealed ut her leg hurting. ne Nurse Practitioner is advised to apply stated they did put 41 did not tolerate ice. minutes later Nurse her hallway again getting bigger on she saw at this point d in size up to the k new she had to be 5 stated the Nurse gain and permission #1 to the hospital.	OVIDER/SUPPLIER/CLIA       (X2) MULTII         NTIFICATION NUMBER:       A. BUILDIN         345381       B. WING         OF DEFICIENCIES       ID         PRECEDED BY FULL       PREFIX         TIFYING INFORMATION)       F 6i         ninistration of       n 5-325 mg (Norco)         was administered       022 at 9:20 PM.         022 at 9:20 PM.       F 6i         0345381       F 6i         04/2022 at 2:59       s on another hallway         her on 6/1/2022 and       big bruise on the leg         palained that it did not       ew how the injury         ained that at the time       ent #1 was taken for         d with a bruise on       d she went to the         v she had a blood       s 3 to 4 inches long         the ankle and below       ed on top. Nurse #5         lister was wrapped       ped and Resident #1         Nurse Practitioner       is advised to apply         stated they did put       et did not tolerate ice.         minutes later Nurse       minutes later Nurse         her hallway again       getting bigger on         she saw at this point       d in size up to the         knew she had to be       5 stated the Nurse         gain and permission<	OVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUAL         NTIFICATION NUMBER:       A. BUILDING         345381       B. WING         STREET ADD       440 INGRAIL         KING, NC       PREFIX         OF DEFICIENCIES       ID         PREFIX       TAG         OF DEFICIENCIES       ID         PREFIX       CO         OF DEFICIENCIES       ID         PREFIX       CO         OF DEFICIENCIES       ID         PREFIX       CO         OF DEFICIENCIES       ID         PREFIX       TAG         OC       STREET ADD         AB(J2022 ADD)       STREET ADD         PREFIX       TAG         ODIAIDED       F 689         Stated that at the time       STREET ADD         ADIAIDAN       STREET ADD         ADIAIDAN       STREET ADD         ADIAIDAN       STREET ADD         Stated that at the time       STREET ADD	DVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION         NTIFICATION NUMBER:       A. BUILDING         345381       B. WING         Generalized and the second the second the second and the second and the second	DVIDERISUPPLERICLIA VITEICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A. BUILDING	OVIDERSUPPLERICLA VITPICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING       (X3) DUE COMP         345381       B. WING       (C) OB/ COMP         0° DEFICIENCIES       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         ninistration of n 5-325 mg (Norco) was administred V22 at 9:20 PM.       F 689         18/4/2022 at 2:59 s on another hallway her on 6/1/2022 and big bruise on the leg plained that it did not ew how the injury ained that it the time ent #1 was taken for d with a bruise on is fak went to the w she had a blood s 3 to 4 inches long the ankle and below do notop. Nurse #5 lister was wrapped iged and Resident #1 Nurse #5 revealed ut her leg hurting, ne Nurse Practitioner s advised to apply tated they did put f1 did not tolerate ice. minutes later Nurse her hallway gain getting bigger on the saw at this point f1 no tolerate ice. minutes later Nurse her hallway gain agetting bigger on the saw at this point f1 no tolerate ice.         with the Medical       I

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 09/07/2022 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING			_		C 09/2022
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VILLAGE	CARE OF KING				40 INGRAM ROAD (ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	on 8/4/2022 at 3:23 P made aware of Resid hospital for a pinched into a bruise and kept that he had decrease for Resident #1 from milligrams per day on explained Resident # left buttock that had re days causing him to in hold and then decrease anticoagulant to 10 m usually a hematoma w very unusual case the did not stop growing r out. An interview was come Administrator on 8/4/2 Administrator revealer 6/2/2022 in the early r being sent to the hosp stated she began her happened on 6/2/2022 NA #8. The Administrator with the family of Res told to the family by R concurred with the ev described by NA #8. NA #8 told her the leg pinched between the when NA #8 turned th on the shower chair. she gave additional in to use the sit to stand stated she was not av	M. MD #1 stated he was ent #1 being sent to the lateral leg that developed growing. MD #1 explained d the Xarelto (anticoagulant) 15 milligrams per day to 10 4/14/2022. MD #1 further 1 had a blood blister on her uptured and bled for two nitially put her Xarelto on sing the dose of the illigrams. MD #1 stated will stop growing but in this e hematoma for Resident #1 hecessitating her to be sent ducted with the facility 2022 at 12:07 PM. The d she was notified on morning hours Resident #1 bital. The Administrator investigation into what 2 which included contacting ator revealed she spoke ident #1 and the events as uesident #1 in the hospital ents of 6/1/2022 as The Administrator confirmed of Resident #1 was bed and the sit to stand lift ie lift to position the resident The Administrator vare Nurse #3 was not by NA #8 when the leg of	F	689				

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					FORM	): 09/07/2022 APPROVED
PROVIDER/SUPPLIER/CLIA	· /				(X3) DATE COMP	SURVEY LETED
345381	B. WING _			_		C 09/2022
		STRE	EET ADDRESS, CITY, STA	ATE, ZIP CODE		
		440 I	INGRAM ROAD			
		KIN	G, NC 27021			
T BE PRECEDED BY FULL	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	TIVE ACTION SHOULD BI		(X5) COMPLETION DATE
22 revealed in the ated in part, "Patient ility after receiving a extremity causing a hematoma. After she hematoma erupted with emergency department] in the hospital course hemorrhagic shock natoma of her right resident #1 had lung collapsed, re, and expired on ath certificate for hed on 6/16/2022, listed eath as "complications oma." Under the ry occurred the death ic injury to right calf batient." ified of the immediate 0:15 AM. ollowing credible	F 6	589				
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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391			
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE COMF	E SURVEY PLETED			
		345381	B. WING				C / <b>09/2022</b>			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
VILLAGE	CARE OF KING				440 INGRAM ROAD KING, NC 27021					
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 689	<ul> <li>#1 back down on the pain. NA #8 used the resident to the shuft Resident #1 a showel on the right leg of Resident #1 to her row NA #4 and NA #10. N Resident #1 from the without the use of a lin Nurse #3 of a large, r Resident #1. R</li></ul>	t. NA #8 then sat Resident bed when she expressed sit to stand lift to transfer ower chair. NA #8 gave r and then noticed a bruise sident #1. NA #8 returned om. NA #8 sought help from A #4 and NA #10 then lifted shower chair onto the bed ft. NA #4 went to notify aised blister on the leg of nt #1 later died, and this er death certificate as a uire assistance with or this issue. day look back of incidents a lift was involved. There olving lists. have been reviewed and een completed as need to riate transfer status. This he Director of Rehabilitation for fehabilitation has esident care plan by the he Minimum Data Set unsfer information was alans in instructive language with either an assist of 1 or d lift, or full lift. This ered to the Kardex for not have access to the care	F	68	39					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/07/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345381	B. WING			_		C 09/2022
NAME OF PI	ROVIDER OR SUPPLIER		<b>I</b>	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VILLAGE	CARE OF KING				40 INGRAM ROAD (ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	different types of lifts i that the staff have cor completed on 8/5/22. o Specify the action the process or system adverse outcome from when the action will b The facility will reeduc staff who assist with the concerning safe trans training was to stop a difficulties and seek h once the resident is so noticeable decline priot the current transfer state member will notify a m follow the nurse's guid any transfers unless of evaluation. The transfer status is Kardex that is access therapists. The stand pivot transfer the number of staff mor resident's transfer state If to elevate the resident is lift to safely transfer to lower the resident with The full lift process ind two staff members at	is in the policy and training mpleted. This process was in the entity will take to alter in failure to prevent a serious in occurring or recurring, and e complete. Cate nursing and therapy ransfers of residents fer processes. Part of their transfer if there were any elp and nursing assessment afe. If the resident has had or to the transfer that makes atus unsafe, the staff nurse for assessment and dance to use a total lift for changed by therapy after an found in the care plan or ible by nursing staff and fer must use a gait belt and embers designated in the	F	689				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 09/07/2022 MAPPROVED ). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345381	B. WING _			_		C 09/2022	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
VILLAGE	CARE OF KING				10 INGRAM ROAD				
				ĸ	ING, NC 27021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	successfully pivot the onto the next surface. There will be a return of the transfer types w reeducation has been and therapy staff who 8/5/22 and will be con staff arrive for work. and agency staff. No prior to training. The Director of Nursir education and return soon as it began. She upcoming assignment training is completed next assignment. Any new hired staff w orientation prior to wo The transfer status fo completed on admissi- change of condition.	sident off the surface and lift to place the resident demonstration using each <i>v</i> ith the reeducation. The completed for all nursing are in the building on npleted ongoing as nursing This includes facility staff one will take an assignment one will take an assignment ag began tracking the demonstration for staff as e will be reviewing the t sheets to ensure that the before the staff take their all receive this training during rking with any resident. r each resident will be on, quarterly, or with a This is the responsibility of	F	89		DEFICIENCY)			
	admission, staff nurse change of condition, a	habilitation department on in the identification of a and the Director of the nent during the quarterly							
	review of the resident Care plans will be upo	lated by the MDS nurses or							
		as changes are made. ne immediate jeopardy							
	The credible allegatio	n was validated on 8/9/2022							

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	0: 09/07/2022 APPROVED 0. 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				(X3) DATE SURVEY COMPLETED C		
		345381	B. WING			_		) 09/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
VILLAGE	CARE OF KING				40 INGRAM ROAD (ING, NC 27021				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	Continued From page as evidenced by: Surveyor was present evidence for removal this visit. Interviews w no issues. Interviews several staff from eac knowledge of the train education training. All educated by 08/05/22	e 23 t on 08/09/22 to review the of the IJ for F 689 during vith alert residents indicated were conducted with th hall who revealed hing on lift skill and I staff had been trained and 2. Observations of staff using ransfer residents revealed	TAG		CROSS-REFEREN	ICED TO THE APPROPRIA			

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