DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED
		345420	B. WING			0.	C 1/17/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
	CE HEALTH CARE CENT	ED			1987 HILTON ROAD		
	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 013 SS=J	CFR(s): 483.73(b)	Policies and Procedures	E	01:	3		2/6/23
	§403.748(b), §416.54 §441.184(b), §460.84 §483.475(b), §484.10 §485.542(b), §485.62 §485.920(b), §486.36 §494.62(b).	(b), §482.15(b), §483.73(b),)2(b), §485.68(b), 25(b), §485.727(b),					
	develop and impleme policies and procedur plan set forth in parag assessment at parag and the communication this section. The poli	edures. [Facilities] must ent emergency preparedness res, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years.					
	procedures. The LTC implement emergence procedures, based or forth in paragraph (a) assessment at paragrand the communication this section. The poli	§483.73(b):] Policies and facility must develop and y preparedness policies and n the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least annually.					
	Facilities: *[For PACE at §460.8 procedures. The PAC develop and impleme policies and procedur plan set forth in parage assessment at parage and the communication	· / -					
	-	SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE		(X6) DATE

Electronically Signed

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

02/01/2023

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 03/13/2023 RM APPROVED IO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED	
		345420	B. WING _		C 01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER	L	1	STREET ADDRESS, CITY, STATE, ZIP COD			
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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
E 013	address managemen emergencies, includir equipment, power, or emergencies; and nat threaten the health or staff, or the public. The must be reviewed and years. *[For ESRD Facilities procedures. The dial and implement emerge and procedures, base set forth in paragraph assessment at paragraph and the communication this section. The poli be reviewed and upda These emergencies in to, fire, equipment or emergencies, water s natural disasters likely geographic area. This REQUIREMENT by: Based on record revi Emergency Medical S review of video surve paramedic, and hosp Physicians/Nurse/Phy interviews, the facility emergency procedure experienced an oxyge not provide emergency whereby he sustained flame burns to both si left chest, left upper a of left hand. Facility s	t of medical and nonmedical ng, but not limited to: Fire; water failure; care-related tural disasters likely to safety of the participants, he policies and procedures d updated at least every 2 at §494.62(b):] Policies and ysis facility must develop gency preparedness policies ed on the emergency plan (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years. nclude, but are not limited power failures, care-related supply interruption, and y to occur in the facility's is not met as evidenced iew, review of the Services (EMS) report, illance footage and staff, ital Attending ysician Assistant/receptionist failed to implement	EO	This allegation of compliance submitted in compliance with law and regulation. To demor continuing compliance with a the center has taken or will ta actions set forth in the following allegations constitutes the cer allegation of compliance. All deficiencies have been or will completed by the dates indicated E013 1. Identify those recipients who	applicable nstrate oplicable law, ke the ng allegation credible nter⊡s alleged be ated.		

Facility ID: 932930

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			A 45 A 46 A 46			ATE 0/
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	ATE SURVEY
			A. BUILDING	3		С
		345420	B. WING			01/17/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		011112023
				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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
E 0.40		_				
E 013	Continued From page		E 01			
		oxygen dependent resident,		suffered, or are likely to suffe		
		covering for a resident when		adverse outcome as a result	of the	
		perature for 1/7/23 was		noncompliance; and		
		eit. When EMS arrived, they 1 slumped over sitting in a		Resident #1 no longer reside	s in the	
		isive and without a pulse or		center. On 1/7/23, shortly be		
		rsonnel immediately began		Resident #1 was noted in do		
		scitation (CPR) once inside		room as the Night Shift Supe	•	
		ent into cardiac arrest twice,		coming down the hall. She c		
		ecame comatose. Resident		smoke was coming from the		
	#1 expired on 01/12/2	23. This deficient practice		began to call his name and a	as she	
	occurred for 1 of 3 rea	sidents reviewed for		approached him, she could s	see his hair	
	supervision to preven	t accidents (Resident #1).		was singed. As she got clos his name, and he did not ans		
	Immediate jeopardy b	began on 01/07/23 when the		head was down. She pushe	d his head up	
		ment their emergency		and back and noted his face	was melted	
		mmediate jeopardy was		off referring to his burned fac		
		when the facility provided		She immediately closed his of		
		e allegation for immediate		smoke detector was soundin	0	
		e facility remains out of		was visible smoke, rescued		
		r scope and severity level of		danger to the nurse's station		
		with potential for more than		pulled the fire alarm and call		
		not immediate jeopardy) to education and monitoring		Emergency Medical Services Fire Rescue at 2:56am. Whi		
	systems put into plac			phone with 911, the Night Sh		
	Findings included:			assessed respirations and provided the information to d	ulse and	
	U			instructed. The 911 dispatch	•	
	Documentation on the	e Nursing Policies and		to get him to the front of the		
	Procedures manual, a			await pickup. The Night Shif	t Supervisor	
		ness plan, dated 10/26/22		instructed the certified nurse	. ,	
	-	policy: "A licensed nurse		to take him to the front of the	-	
		cy first aid as indicated by		await EMS at the request of		
	-	e in the center experiencing		dispatch. In the meantime, t	-	
		nt." Procedures included:		Supervisor was asked to sta		
		may include but is not limited		phone with the dispatcher.		
		nary resuscitation], Rescue bleeding/hemorrhage,		initiated the fire plan, to inclue evacuation of immediate are		
	administration of eme			fire extinguisher to extinguisl	a, anu use ui	

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		MEDICAID SERVICES				OMB NC		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDING	G				
		345420	B WING				C	
		345420	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	01/	17/2023	
NAME OF P	ROVIDER OR SUPPLIER							
ALAMAN	CE HEALTH CARE CENT	ER			87 HILTON ROAD			
	1			BU	JRLINGTON, 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)		(X5) COMPLETIO DATE	
E 013	Continued From page	3	É 01	13				
2010	of pressure dressings			13	the nationt a ream until the fire			
		immobilization of fractures."			the patient⊡s room, until the fire department arrived.			
	ocarising of wounds,				During the wait for EMS to arrive, the	CNA		
	Resident #1 was adm	nitted to the facility on			states she and other staff watched him			
		e diagnoses that included			took his pulse, and she and other staff			
	Chronic Obstructive F				continued to speak to him and touch h			
		art failure, and tobacco use.			to reassure him knowing he was			
					unresponsive. His body was severely			
	Resident #1 was desi	ignated as being a Full			slumped over in the chair at his torso.			
	Code.				The CNA notes on interview that she a	and		
					other staff handed him off to EMS upo			
		ated 12/29/22 indicated			their arrival at 3:02am. They dismisse	d		
		eceive oxygen at 4 liters per			themselves when EMS took over.			
		nula every day and night			Administration, to include Administrato			
	shift.				Director of Nursing, Chief Nursing Offi Medical Officer and VP of Operations	cer,		
	The nursing note writ	ten by the Night Shift			reviewed the facility s emergency			
		ctronic medical record of			preparedness plan which includes the	Fire		
		/07/23 at 3:15 AM stated,			Plan on $1/12/23$ and determined the	1 110		
		sponsive and breathing in			facility did not implement the plan in th	at a		
		W/C [wheelchair] with burns			nurse failed to provide direct care			
		sferred to nurses' station			monitoring of Resident #1 until arrival	of		
		icted by 911 to bring resident			EMS for six minutes. The nurse that			
	to front of building by	EMS and transferred care			responded initially and the staff that			
	to EMS."				assisted him after he left the unit to go			
					front of the building failed to monitor a	nd		
		ducted with the Night Shift			assess Resident #1 who had been			
		23 at 10:30 AM. Night Shift			through a traumatic event suffering	ina		
		about 3:00 AM on 01/07/23			multiple burns. They did not assess h fully to know what nursing and medica			
		nurses' station when she eeping sound," which she			needs he had, did not position the	I		
		s the room's smoke detector			resident to promote breathing, did not			
		to investigate the noise. As			cover the resident in 30-degree weath	er		
		hall, she saw and smelled			outside, and did not provide basic			
		rom Resident #1's room.			necessary services until EMS arrived.			
	She yelled "I know yo				The nurse further sent him to the lobby	/		
		he reached Resident #1,			with an unlicensed staff member who			
		oorway of his room, sitting			unable to monitor him which was requ			
	upright with his head	down. She lifted his head			per policy. There were no revisions to	tho		

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	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	LETED
							C
		345420	B. WING			01/	17/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	CE HEALTH CARE CENT	FR		19	987 HILTON ROAD		
				В	URLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 013	Continued From page	o 1	Í –	040			
L 015				013			
		t #1's face and hair severely			emergency plan required.		
		thing, and unresponsive. She ourns as "it was like his face			2 Specify the action the optity will tak	e to	
		ediately brought Resident #1			Specify the action the entity will tak alter the process or system failure to		
		is wheelchair and closed the			prevent a serious adverse outcome fro	om	
		m to the nurses' station,			occurring or recurring, and when the	••••	
		and called 911. She stated			action will be complete.		
		y 911 to escort Resident #1			1		
		Iding and to stay on the			Education on the emergency		
	phone. She instructe	d Nursing Assistant #1 (NA)			preparedness plan, specifically the Fi	re	
	to push Resident #1	to the front of the building.			Plan, began to all staff on 1/12/23 by	the	
	She stated she had o	checked Resident #1 for a			DON or designee. This education		
		is but could not remember			included:		
		his pulse was strong, and his			" First response in area of smoke of	or	
	-	al. She stated she did not			fire, to include rescuing patients from		
		to stay with Resident #1			smoke or fire.		
		prried about evacuating the			Containing and/or extinguishing t	he	
	other residents.				fire/smoke		
	A review of the video	our cillones festars on			Use of file extinguistiers		
	01/07/23 revealed Re	surveillance footage on			 Departmental Instructions for Fire Plan 	;	
	assisted outside by th	.				ilitice	
		wheelchair, slouched, with			to each department in the event of a f		
		s, and arms dangling off the			smoke, and/or evacuation needs.		
		air, limp, with no movement.			¿ Licensed nurses are to provide d	irect	
		the staff members stepped			assistance to patients within the fire p		
		nber remained behind			and departmental designations, which		
		aff member who stepped to			would follow the policy for Emergency		
		Resident #1. She crouched			First Aide, Nursing Policy 1101.		
		ident #1's face, stood up,			" Provision of emergency first aide		
	-	iched him. Four additional			indicated by the situation to anyone in	the	
		the building and walked			center experiencing an accident or		
	-	esident #1 remained sitting in			incident.		
		ched, with his chest to his			" A licensed nurse will assess injur		
		igling off the sides of the			persons, obtain vitals, monitor patient		
	-	n no movement until EMS			changes. Obtain vital signs, pulse ox	etc.	
		ave a blanket or jacket to			as condition warrants.		
	provide protection fro	om cola temperature.			" In the case of burn, protect airwa	-	
					such as positioning, rescue breathing	,	

Facility ID: 932930

		MEDICAID SERVICES			OMB NO. 0938-0	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
					с	
		345420	B. WING		01/17/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
ALAMANO	E HEALTH CARE CENT	ER		1987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLET THE APPROPRIATE DATE	
E 013	Continued From page	e 5	E 01	13		
		cuweather.com, the low		CPR, emergency oxygen		
	, and the second s	degrees Fahrenheit on		 Providing emergency 		
	1/07/23 in Burlington.	-		other accidents/incidents		
	-			Rescue breathing, contro	-	
		#1 on 01/09/23 at 3:36 PM		emergency oxygen, clear		
		t assigned to work with		wounds/applying dressing	g, immobilizing	
		7/23. She responded to the		fractures.		
		when she arrived at the vas instructed by the Night		Consider weather an covering should patient b		
		ing Resident #1 to the		" Notification to physic		
		uilding. She indicated she		as soon as possible.		
		uries and described them as		" Contacting EMS		
	-	off his face and his hair was		" Assuring that license	d staff attend	
	burned on the side."	She indicated she was not		resident until EMS arrives		
	given other instruction	ns from the Night Shift		monitor, assess and inter	vene as needed	
		providing aid to Resident		" Completion of docum	nentation related	
	#1.			to the incident		
	Nurse #1 was intervie	ewed on 01/22/23 at 2:58		Any staff member that did	I not receive	
		e was assigned to work with		education on 1/12/23 will		
		7/23 and knew Resident #1		education by the beginnin	-	
		kygen. She indicated she		shift by the DON or desig		
		when the incident occurred.		hire licensed staff will be	-	
		of the building because she staff members Resident #1		Staff Development Coord this policy. The Staff Dev	. ,	
	-	hile smoking a cigarette.		Coordinator will retain the	-	
		d at the front of the building,		those who continued to n	5	
		ived. She indicated when		assure all staff are educa	-	
	· · ·	, his head was down, and he		emergency preparedness		
		he did not assess Resident		specifically the fire plan a	-	
		already arrived. Later in the		responsibilities.		
		the first time she checked		" The DON or designe	-	
	-	se and respirations was		understanding of the edu	-	
		front of the building. She		oral discussion and feedb		
		spirations manually and		and notate this on a track	-	
		/as shallow and his pulse n normal range. She stated		SDC will also do this in or Licensed nurses will com		
	-	ber the pulse or respiration		for their education on Nur		
		ser are puise or respiration				

Facility ID: 932930

					(A) =	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
			A. BUILDING	<u> </u>		С
		345420	B. WING		0	1/17/2023
	ROVIDER OR SUPPLIER	010120		STREET ADDRESS, CITY, STATE, ZIP COL		1/1//2023
				1987 HILTON ROAD		
ALAMANO	CE HEALTH CARE CEN	TER		BURLINGTON, NC 27217		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLETIO
TAG	· · ·	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	DATE
E 013	Continued From pag	le 6	E 01	3		
	-	g providing aid to Resident		will conduct the testing.		
		ate why she had not stayed		" A fire drill will occur on a	ll each	
	with Resident #1.	, ,		12-hour shifts beginning on 1	/13/23, which	
				will include the provision of s		
	NA #3 was interview	ed on 01/10/23 at 10:25 AM.		injured patient from smoke		
	She indicated she w	as assigned to work with		inhalation/burns, for response	e, further	
		7/23, was familiar with his		education needed, and confi		
		w he was oxygen dependent.		education understood. This v		
		checked 10 to 15 minutes		conducted by Maintenance D	irector, SDC,	
	•	She indicated she was		and Director of Nursing.		
		ig and was not on the floor				
		curred. The first time she		3. Address what measures w		
		er the incident was when he		place or systemic changes m		
	was outside on the s	stretcher with EMS.		ensure that the deficient prac	cice will not	
	Decumentation of th	o Emorgonov Modical		recur;	have the	
		e Emergency Medical ort dated 01/07/23 revealed at		In addition to the education a Facility Administrator, DON, I		
		ed on scene. Resident #1 was		Director and/or designee will		
		ir outside of the front door of		emergency simulation events		
	the facility. Resident			weeks, then twice monthly x1		
	-	ver in the wheelchair. Staff		ensure compliance is achieve		
	· ·	ked if the resident was		of emergency response.		
		resident had a pulse. The				
		ded, "he's unconscious."		4. Indicate how the facility pla	ans to	
		in, asked if the resident was		monitor its performance to m		
		ad a pulse, "to which the		solutions are sustained;		
		check the patient." EMS		The Administrator will be resp	oonsible for	
	noted all nursing sta	ff had no hands on the		the findings from the audits a		
		t was not being assessed,		to the Quality Assurance Per		
		dministered by nursing staff		Improvement (QAPI) commit		
		EMS personnel quickly		recommendations and/or mo		
		nt. The resident was found to		until a pattern of compliance		
		nave a pulse. EMS personnel		The Administrator is respons	ible for the	
		aff about Resident #1's		entire plan of correction.		
	information and pape					
		don't know anything about		5. Date of completion 2/06/20	023	
	-	e is a fire, so we can not [sic]				
		tion." It was noted that ed to enter and exit the front				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/13/2023 APPROVED . 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345420	B. WING			C 01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE	E, ZIP CODE	•		
			1	987 HILTON ROAD				
ALAMAN	CE HEALTH CARE CENT	ER	E	BURLINGTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE	
E 013	Continued From page doors of the facility.	97	E 013					
	Paramedic on 01/11/2 Paramedic stated whe Resident #1 slumped in front of the facility. he was breathing. The around Resident #1; I hand their hands on F members were either around. He further inc not report if Resident pulse. He also stated provide him Resident medical conditions. W #1 it was determined pulse or respirations. to the stretcher via 2- cardiopulmonary resu in the ambulance. The Emergency Roor Resident #1 presente partial-thickness burn face and neck as well approximately 10% of soot in the nostrils. Th physician noted EMS sitting in wheelchair w cannula when he sub exploded in his face of face, neck, shoulders was noted to be unres CPR was initiated by for 30 minutes then hi returned. Resident #1	en he arrived, he saw over in a wheelchair outside Resident #1 did not look like ere were staff members nowever, no staff member Resident #1. He stated staff on their phones or walking dicated staff members could #1 was breathing or had a facility staff was not able to #1's name, date of birth, or /hen he assessed Resident Resident #1 did not have a Resident #1 was assessed person manual lift and iscitation (CPR) was started is covering Resident #1's as clavicle and shoulder, f body surface area, and						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	
		345420	B. WING	ING	<u> </u>		C 17/2023
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	17/2023
					1987 HILTON ROAD		
	E 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)	ED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETION DATE
E 013	hospital initiated a tra A review of the Burn A Unit (ICU) hospital no Resident #1 was critic second- and third-deg sides of his face, both arm, left forearm, and his body. It was noted cardiac arrest twice a respiratory failure sec (excess fluid in the lun An interview with ICU on 01/09/23 at 3:02 P #1 was comatose, int and had an anoxic bra caused by a complete brain). Resident #1's from Full Code to Do The ICU Physician As 01/10/23 at 12:32 PM reported to her that R the facility and caugh unresponsive and rem admission to the ICU injuries were consiste oxygen. The ICU Attending Ph 01/11/23 at 9:39 AM v time of the call, Resid injury (brain injury wh oxygen to the brain) a	his significant burns, the nsfer to a local burn unit. Attending Intensive Care the dated 01/07/23 revealed cally ill and sustained gree flame burns to both n ears, left chest, left upper l back of left hand to 5.5% of d that he also went into s well has having acute condary to pulmonary edema ings) and aspiration. Nurse #1 was conducted M. She indicated Resident ubated, unable to speak, ain injury (a brain injury e lack of oxygen to the code status was switched Not Resuscitate (DNR). esistant was interviewed on l. She indicated it was esident #1 was smoking at t fire. He was found to be nained unresponsive since burn unit. She stated his ent with smoking while on hysician was interviewed on via phone revealed at the lent #1 had an anoxic brain ich occurs due to lack of and had a poor prognosis.	E	01:			
		dicated she did not expect a lliative care consult would					

Facility ID: 932930

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/2023 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE		
			A. BUILDI	NG_			c	
		345420	B. WING			01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
	CE HEALTH CARE CENT	ER			1987 HILTON ROAD			
, (L) (11) (14)				E	BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
E 013	be placed due to Res	9 ident #1's poor prognosis. Nurse #2 was conducted M. She indicated Resident	E	013				
	#1 remained in critica placed on comfort car treatment. He was no death was imminent.	I condition. Resident #1 was e with no aggressive t expected to recover, and						
		PM the ICU Receptionist indicated Resident #1 died M.						
	on 01/09/22 at 1:57 P a call from a staff mer 1/07/22 notifying her injuries from lighting a She indicated she did she arrived at the faci taken by ambulance; to assess Resident #	ng (DON) was interviewed M. She stated she received mber around 3:00 AM on of Resident #1 sustaining a cigarette while on oxygen. not see Resident #1 when lity as he had already been therefore, she was unable 1. She indicated she felt the opriately to the emergency.						
	The Administrator was jeopardy January 11, The facility provided t allegation for immedia	he following credible						
		nts who have suffered, or serious adverse outcome as npliance; and						
	noted in doorway of h Supervisor was comir see that smoke was c	ore 3AM, Resident #1 was is room as the Night Shift ng down the hall. She could coming from the room. She e and as she approached						

Facility ID: 932930

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345420	B. WING	-			C 17/2023
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2020
				1	1987 HILTON ROAD		
ALAMANO	E HEALTH CARE CENT	ER		E	BURLINGTON, NC 27217		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 013	got closer, she called answer as his head w head up and back and "melted off" referring She immediately close detector was soundin smoke, rescued him f station, immediately p called 911 for Emerge (EMS) and Fire Resc phone with 911, the N assessed respirations information to dispato dispatcher asked her building to await pick Supervisor instructed (CNA) to take him to await EMS at the requ the meantime, the Nig asked to stay on the p Other staff initiated th evacuation of immedii extinguisher to exting room, until the fire de During the wait for EM she and other staff wa and she and other staff wa and she and other staff wa interview that she and to EMS upon their arr dismissed themselves Administration, to incl	s hair was singed. As she his name, and he did not vas down. She pushed his d noted his face was to his burned face. ed his door given the smoke g and there was visible from danger to the nurses bulled the fire alarm and ency Medical Services ue at 2:56am. While on the light Shift Supervisor is and pulse and provided the sh as instructed. The 911 to get him to the front of the up. The Night Shift the certified nurse aide the front of the building to uest of the 911 dispatch. In ght Shift Supervisor was obnone with the dispatcher. e fire plan, to include ate area, and use of fire uish smoke in the patient's partment arrived. MS to arrive, the CNA states atched him, took his pulse, aff continued to speak to him asure him knowing he was ody was severely slumped is torso. The CNA notes on d other staff handed him off	E	013	3		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		345420	B. WING			C 01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	·		
ALAMAN	CE HEALTH CARE CENT	ER			87 HILTON ROAD JRLINGTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ACTION SHOULD BEREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE		
E 013	and VP of Operations emergency prepared Fire Plan on 1/12/23 a did not implement the to provide direct care until arrival of EMS for that responded initiall him after he left the u building failed to mon who had been throug multiple burns. They know what nursing ar did not position the re- did not cover the resid outside, and did not p services until EMS ar sent him to the lobby member who was una was required per polit to the emergency plat Specify the action the process or system fai adverse outcome fror when the action will b o Education on the plan, specifically the F on 1/12/23 by the DO education included: o First response in include rescuing patie o Containing and/of fire/smoke o Use of fire exting o provides guidant	a reviewed the facility's hess plan which includes the and determined the facility a plan in that a nurse failed monitoring of Resident #1 r six minutes. The nurse y and the staff that assisted nit to go the front of the itor and assess Resident #1 h a traumatic event suffering did not assess him fully to not medical needs he had, esident to promote breathing, dent in 29-degree weather rovide basic necessary rived. The nurse further with an unlicensed staff able to monitor him which cy. There were no revisions n required. • entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete. • emergency preparedness Fire Plan, began to all staff N or designee. This area of smoke or fire, to ents from smoke or fire, to e	E	013				

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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				_ 17/2023
	ROVIDER OR SUPPLIER	ER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 013	 Licensed nurses assistance to patients departmental designat the policy for Emerge Policy 1101. Provision of eme by the situation to any experiencing an accid o A licensed nurse obtain vitals, monitor vital signs, pulse ox e o In the case of bu positioning, rescue broxygen o Providing emerge accidents/incidents as breathing, control blec cleansing wounds/apt fractures. Consider weather should patient be take o Notification to ph as possible. Contacting EMS o Assuring that lice until EMS arrives, cor and intervene as need o Completion of do incident Any staff member education on 1/12/23 beginning of the next designee. All new hir educated by the Staff (SDC) on this policy. Coordinator will retain 	are to provide direct within the fire plan and titions, which would follow ncy First Aide, Nursing rgency first aide as indicated yone in the center dent or incident. will assess injured persons, patient for changes. Obtain tc. as condition warrants. rn, protect airway, such as reathing, CPR, emergency ency first aide for other is needed-CPR, Rescue eding, emergency oxygen, plying dressing, immobilizing r and need for covering en outside ysician/Next of Kin as soon ensed staff attend resident ntinue to monitor, assess ded boumentation related to the r that did not receive will receive education by the shift by the DON or re licensed staff will be Development Coordinator The Staff Development o the master log of those d education, to assure all	E	013	3		

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING				C 17/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANO	E 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
E 013	 preparedness plan, sidepartmental responsion o The DON or designed and the discussion and feedby this on a tracking tool in orientation. License post-test for their edu 1101. Post-test will be will conduct the testim o A fire drill will occubeginning on 1/13/23 provision of services a smoke inhalation/burreducation needed, ar understood. This will Maintenance Director Nursing. IJ removal date is Jarr Person responsion of the administrator. On 01/17/23, the facili immediate jeopardy record review of in-set with facility staff reveation on the facility's policies smoke or fire, fire extidocumentation review Maintenance Director 	pecifically the fire plan and sibilities. Ignee will verify the education through oral ack with all staff and notate . The SDC will also do this sed nurses will complete a cation on Nursing Policy egin on 01/13/2023. SDC g. cur on all three shifts , which will include the to an injured patient from hs, for response, further ad confirmation of education be conducted by c, SDC, and Director of huary 14, 2023. consible for implementation is ity's credible allegation for emoval was validated by ervices; multiple interviews aled they received education as regarding responding to inguishers, and fire plan; v and interview with the	E	01			
	Staff Development Co Nursing, and Adminis	oordinator, Director of trator regarding the . Immediate jeopardy was					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/2023 MAPPROVED D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING _				C 17/2023
NAME OF PF	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANO	E HEALTH CARE CENT	ER			987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	on 01/09/2023 throug complaint allegations NC00196780 and NC investigated. Intake N immediate jeopardy. E Immediate Jeopardy N CFR 483.12 at tag F6 CFR 483.25 at tag F6 CFR 483.25 at tag F6 CFR 483.73 at tag E0 J The tags F600, F684, Substandard Quality of	C00196780 resulted in Event ID # T2J111. was identified at: 00 at a scope and severity J 84 at a scope and severity J 89 at a scope and severity J 013 at a scope and severity and F689 constituted					
	A partial extended sur 01/17/23.	vey was conducted on					
F 550 SS=D	from a video of a vide	2)(b)(1)(2)	F	550			2/6/23
	The resident has a rig self-determination, an access to persons and	ht to a dignified existence, d communication with and					
	§483.10(a)(1) A facilit	y must treat each resident					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							<i>I</i> APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING			C 01/17/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
		50		1	987 HILTON ROAD		
ALAMAN	CE HEALTH CARE CENT	ER		E	BURLINGTON, NC 27217		
(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 B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 550	with respect and dign resident in a manner a promotes maintenanch her quality of life, reco- individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, of must establish and map ractices regarding tra- provision of services of residents regardless of §483.10(b) Exercise of the resident has the of rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res- free of interference, co- reprisal from the facili rights and to be suppor exercise of his or her subpart. This REQUIREMENT by: Based on observation facility failed to treat a manner when facility a out the front door of the	ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. Solity must provide equal regardless of diagnosis, for payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.	F	550	F550 1. Identify those recipients who have suffered, or are likely to suffer, a seriou adverse outcome as a result of the noncompliance; and	IS	

Facility ID: 932930

		ND HUMAN SERVICES MEDICAID SERVICES			F	NTED: 03/13/2023 ORM APPROVED NO. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED		
		345420	B. WING _			C 01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE			
				1987 HILTON ROAD				
ALAMANO	CE 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	((EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE		
F 550	second and third deg ears, left side of chest forearm, and back of unconscious and rem wheelchair wearing of and pajama bottoms temperature was rece Fahrenheit on accuw EMS for 1 of 1 reside (Resident #1). The findings included Resident #1 was adm 12/29/22 with multiple Chronic Obstructive I respiratory failure, pe heart failure, tobacco The nursing note writ Supervisor in the elec Resident #1 dated 07 "Resident found unre front of room door in to face and hair. Trar and called 911. Instru- to front of building by to EMS." An interview was con Supervisor stated at she was sitting at the heard "an annoying b later discovered it was	he sustained significant gree burns to his face, both st, left upper arm, left left hand. Resident #1 was hained slumped over in his only a short-sleeved T-shirt when the lowest orded to be 29-degrees reather.com while waiting for ent reviewed for dignity d: hitted to the facility on the diagnoses which included Pulmonary Disease, stripheral vascular disease,	F 5		resides in the ave the potential to a deficient practice. a entity will take to tem failure to rese outcome from and when the d by the Staff tor on 1/27/23 to all rights, dignity and , including properly clothed litions, and eceive care and instructed to tions of resident part of the at were not Il receive education cation on resident portion on resident ontinue to occur as ation. I be interviewed espect using a 23 to determine if olations of dignity ents. Follow-up ility investigation as needed. ures will be put into ges made to t practice will not use of the same			
	An interview was con Supervisor on 01/09/ Supervisor stated at she was sitting at the heard "an annoying b later discovered it wa going off. She got up she walked down the	23 at 10:30 AM. Night Shift about 3:00 AM on 01/07/23 nurses' station when she beeping sound," which she is the room's smoke alarm		 and external reporting a 3. Address what measu place or systemic changers ensure that the deficien recur; Monitoring will include u 	as needed. Ires will be put into ges made to t practice will not use of the same nts, to interview 15 beeks, then biweekly			

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMF	PLETED	
					С		
		345420	B. WING		01/	17/2023	
NAME OF P	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 550	Continued From page	e 17	F 550				
	the doorway of his roo head down. She lifted Resident #1's face ar was breathing, and un his facial burns as "it She immediately broo hallway via his wheel She pushed him to th fire alarm, and called instructed by 911 to e front of the building a instructed Nursing As Resident #1 to the fro not provide any further A review of the video 01/07/23 revealed Re assisted outside by th Resident #1 was in a his chest to his knees sides of the wheelchar Once outside, two of away. One staff mem Resident #1. One staff the side, returned to F down, looked at Resid and intermittently tour staff members exited past Resident #1. Re the wheelchair, slouc knees, and arms dan wheelchair, limp, with arrived. He did not ha provide protection fro	nree staff members. wheelchair, slouched, with s, and arms dangling off the air, limp, with no movement. the staff members stepped		 completed by the DON, Director of Work or designee. Any identified will be addressed immediately wit investigation and external reportinneeded. 4. Indicate how the facility plans the monitor its performance to make solutions are sustained; The Administrator will be response information that is reported to the Assurance Performance Improve (QAPI) committee for recommend and/or modifications until a patter compliance is achieved. The Administrator is responsible the entire plan of correction 5. Date of completion: 2/06/2023 	issues th ng as o sure that ible for Quality ment dations n of		
		#1 on 01/09/23 at 3:36 PM assigned to work with					

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345420	B. WING			C 01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMANO	CE HEALTH CARE CENT	ER			987 HILTON ROAD URLINGTON, NC 27217			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC 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 550 F 600 SS=J	Resident #1 on 01/07 fire alarm sound and y nurses' station, she w Shift Supervisor to bri outside front of the bu saw Resident #1's inju "his skin was peeled of burned on the side." If short sleeve shirt and indicated she was not from the Night Shift S providing aid to Resid what Resident #1 was she could not rememine #1 with a covering to 37-degree Fahrenheit Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemi treat the resident's me §483.12(a)(1) Not use physical abuse, corpor involuntary seclusion; This REQUIREMENT by: Based on record revi	 /23. She responded to the when she arrived at the ras instructed by the Night ing Resident #1 to the uilding. She indicated she uries and described them as off his face and his hair was Resident #1 was wearing a pajama bottoms. She is given other instructions upervisor regarding lent #1. She could not recall is wearing. She further stated ber if she provided Resident protect him from the it temperature. Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, effined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must-e verbal, mental, sexual, or oral punishment, or 		550	F600 1. Identify those recipients who have		2/6/23	

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						<u>10. 0938-03</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED
			A. BUILDING	3		С
		345420	B. WING			1/17/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/1//2023
				1987 HILTON ROAD		
ALAMAN	CE 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 600	Continued From page	e 19	F 60	00		
		t and staff, paramedic and		suffered, or are likely to suffer,		
	-	ws, the facility staff neglected		adverse outcome as a result of	the	
		services after a resident		noncompliance; and		
		en explosion and sustained		Resident #1 no longer resides i		
		gree flame burns to both		center. The facility failed to pro		
		h ears, left chest, left upper		and services to Resident #1 aft		
		d back of left hand. Resident and slumped over in his		sustained significant facial injur as 2nd and 3rd degree burns. F		
		was wheeled out of the		was unresponsive and was whe		
	facility. Facility staff			outside slumped over in his wh		
		ent and failed to position the		No attempts were made to main		
	-	an open airway or render any		open airway or assess the resid		
		AS arrived, Resident #1		nursing or medical needs.		
	remained slumped ov	-		On 1/7/23, shortly before 3AM,	Resident	
		ithout a pulse or respirations.		#1 was noted in doorway of his		
	-	o cardiac arrest twice before		the Night Shift Supervisor was		
	arriving at the hospita	al, required intubation, and		down the hall. She could see the		
	became comatose du	ue to his injuries. Resident		was coming from the room. Sh	e began to	
	#1 expired on 01/12/2	23. This is evidenced for 1 of		call his name and as she appro	ached him,	
	3 residents reviewed	for supervision to prevent		she could see his hair was sing	ed. As	
	accidents (Resident	#1).		she got closer, she called his n	ame, and	
				he did not answer as his head		
		began on 01/07/23 when the		She pushed his head up and ba		
		d to provide necessary		noted his face was melted off re	eferring to	
		#1 after he sustained third		his burned face.	·	
		sides of his face, both of his		She immediately closed his doo		
		rees burns on his left chest,		smoke detector was sounding a		
		rearm, and back of left hand.		was visible smoke, rescued him		
		of the facility unconscious his wheelchair and facility		danger to the nurse's station, in pulled the fire alarm and called		
		tood adjacent to the resident		Emergency Medical Services (E		
	-	en his airway or render any		Fire Rescue at 2:56am. While		
		ate jeopardy was removed on		phone with 911, the Night Shift		
		icility provided an acceptable		assessed respirations and puls	•	
		r immediate jeopardy		provided the information to disp		
		remains out of compliance at		instructed. The 911 dispatcher		
		everity level of "D" (No actual		to get him to the front of the bui		
				-	-	
	i nami with polennal ic	or more than minimal harm		await pickup. The Night Shift S	upervisor	

Facility ID: 932930

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	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	OMB	RM APPROVE NO. 0938-039 ATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	` ´	G		MPLETED	
		345420	B. WING		C 01/17/2023		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE		
				1987 HILTON ROAD			
ALAMANG	CE HEALTH CARE CEN	IER		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 600	Continued From page	10.20	Ге	00			
1 000	Continued From pag		F 6				
		tion and monitoring systems		to take him to the front of			
	put into place are eff	ecuve.		await EMS at the request dispatch. In the meantime			
	Findings included:			Supervisor was asked to s	. 0		
	i mango moladoa.			phone with the dispatcher			
	Cross Refer to F684	:		nurse did not provide inst			
				certified nurse aide as to	what to do for		
	Based on record review, review of video surveillance footage and Emergency Medical Service (EMS) report and staff, paramedic and			this resident; she didn⊟t a	assess what the		
				resident needed and faile			
				emergency care to mainta	ain Resident #		
		hysicians/Nurse/Physician		1⊡s airway.			
	-	st interviews, the facility failed		During the wait for EMS to			
	-	sness of 3rd degree facial not provide continuous		states she and other staff took his pulse, and she ar			
		ent #1's vital signs or assess		continued to speak to him			
	-	mine the need for nursing or		to reassure him knowing h			
		s until Emergency Medical		unresponsive. His body v			
		sident #1 sustained second		slumped over in the chair			
	and third degree bur	ns to his face, both ears, left		The CNA notes on intervie	ew that she and		
		per arm, left forearm, and		other staff handed him off			
		lditionally, the low outdoor		their arrival at 3:02am. Th	•		
		7/23 was recorded as		themselves when EMS to			
	-	eit, and Resident #1 was only		In review of this incident, t			
		pants and a short sleeve Resident #1 was described by		staff assigned to him after failed to monitor and asse			
		ng "slouched/slumped over in		who had been through a t			
		n they arrived, and he was		suffering multiple burns, c			
		eathing. EMS personnel		him fully to know what nu			
		cardiopulmonary resuscitation		medical needs he had, die	•		
	, ,	bulance. Resident #1 went		resident to promote breat			
		equired intubation, and		cover the resident in 37-d			
		ue to his injuries. This		outside, and did not provid			
	-	curred for 1 of 3 residents		necessary services until E			
	reviewed for supervi	sion to prevent accidents.		The nurse further sent hin with an unlicensed staff m	•		
	The Administrator w	as notified of immediate		unable to monitor him whi			
		13, 2023, at 10:50 AM.		per policy.			
					r poglact		
	The facility provided	the following credible		All residents are at risk for	negieci.		

Facility ID: 932930

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		ND HUMAN SERVICES MEDICAID SERVICES				F	NTED: 03/13/202 ORM APPROVE NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		DATE SURVEY COMPLETED	
		345420	B. WING			01/17/2023		
NAME OF PF	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
ALAMANC	E HEALTH CARE CENT	ER			987 HILTON ROAD URLINGTON, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 21	F	600				
		ate jeopardy removal:						
	v				2. Specify the action the entity will ta	ake to		
		nts who have suffered, or			alter the process or system failure to			
		serious adverse outcome as			prevent a serious adverse outcome			
	a result of the noncor	•			occurring or recurring, and when the	9		
		provide care and services to had sustained significant			action will be completed.			
		l as 2nd and 3rd degree			Education began for nursing staff to			
	-	as unresponsive and was			include licensed nurses and nursing			
		nped over in his wheelchair.			assistants on 1/12/23, by the DON o			
	No attempts were ma	ade to maintain an open			designee. Education included Nurs	ing		
	•	resident for nursing or			policy 1110-Emergecy First Aide, an			
	medical needs.				other information noted below. Edu included:			
	-	fore 3AM, Resident #1 was			" Provision of emergency first aid			
		nis room as the Night Shift			indicated by the situation to anyone	in the		
	-	ng down the hall. She could			center experiencing an accident or			
		coming from the room. She ne and as she approached			incident. A licensed nurse will assess inj	ured		
		is hair was singed. As she			persons, obtain vitals, monitor patie			
		I his name, and he did not			changes. Obtain vital signs, pulse of			
	-	vas down. She pushed his			as condition warrants.			
		d noted his face was			" In the case of burn, protect airw	/ay,		
	"melted off" referring	to his burned face.			such as positioning, rescue breathin	ıg,		
	a				CPR, emergency oxygen.			
	-	sed his door given the smoke			" Providing emergency first aide			
		ng and there was visible			other accidents/incidents as needed	I-CPR,		
		from danger to the nurses pulled the fire alarm and			Rescue breathing, control bleeding, emergency oxygen, cleansing			
		ency Medical Services			wounds/applying dressing, immobili	zina		
	•	ue at 2:56am. While on the			fractures.			
		Night Shift Supervisor			" Notification to physician/Next of	f Kin		
		s and pulse and provided the			as soon as possible.			
		ch as instructed. The 911			" Contacting EMS			
	-	to get him to the front of the			" Assuring that licensed staff atte			
	building to await pick				resident until EMS arrives, continue			
		l the certified nurse aide the front of the building to			monitor, assess and intervene as ne Completion of documentation re			
	await EMS at the req					Jaieu	1	

Facility ID: 932930

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/1 FORM APPF OMB NO. 0938	ROVED
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED C	Y
		345420	B. WING _		01/17/202	23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	•	-
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 PREFI) TAG	X (EACH CORRECTIV CROSS-REFERENCE	E ACTION SHOULD BE COMP	X5) PLETION ATE
F 600	the meantime, the Nig asked to stay on the p However, the nurse do the certified nurse and resident; she didn't as needed and failed to maintain Resident # 1 During the wait for EM she and other staff wa and she and other staff wa and so the staff wa and she and other staff wa and she and other staff wa and she and other staff wa and touch him to reas unresponsive. His bo over in the chair at his interview that she and to EMS upon their arr dismissed themselves In review of this incide assigned to him after monitor and assess F through a traumatic e burns, did not assess nursing and medical in position the resident in and did not provide b EMS arrived. The nu lobby with an unlicent unable to monitor him policy. All residents are at ris Specify the action the process or system fail	ght Shift Supervisor was obone with the dispatcher. id not provide instruction to le as to what to do for this seess what the resident render emergency care to l's airway.	F	 Education began for a neglect began on 01/1 development coordina included information reabuse and neglect as administrative in policy guide for reporting, ab reporting requirements and occurrences. Any nursing staff mem receive education on 1 education by the begin shift by the DON or de Development Coordina responsible for tracking require education. An received education will work until education is hire licensed staff will 1 Staff Development Coordina orientation process. Si was notified of this responsible of this responsister of the resp	II staff on abuse and 3/2023 by staff tor. Education egarding types of referenced in 704 reference use policy 703 s for unusual events ther that did not 1/12/23 will receive ning of the next signee. The Staff ator will be g staff that still y staff that has not I not be allowed to received. All new be educated by the ordinator on this will be added to the taff Development ponsibility on will verify the education through edback with all staff acking tool. The n orientation.	
	assigned to him after monitor and assess F through a traumatic e burns, did not assess nursing and medical i position the resident f cover the resident in a and did not provide b EMS arrived. The nu lobby with an unlicens unable to monitor him policy. All residents are at rise Specify the action the process or system fail	he left the unit failed to Resident #1 who had been vent suffering multiple him fully to know what needs he had, did not to promote breathing, did not 30 degree weather outside, asic necessary services until rse further sent him to the sed staff member who was a which was required per sk for neglect.		require education. An received education will work until education is hire licensed staff will I Staff Development Co- policy. This education orientation process. St was notified of this res 01/12/2023. The DON or designee understanding of the e oral discussion and fee and notate this on a tra SDC will also do this in Nursing staff will comp based on the educatio Development Coordina	y staff that has not I not be allowed to received. All new be educated by the ordinator on this will be added to the taff Development ponsibility on will verify the education through edback with all staff acking tool. The n orientation.	

Facility ID: 932930

	-	D HUMAN SERVICES				FORM	M APPROVED
	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		COMPLETED	
		345420	B. WING _				C 17/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		11/2020
	CE HEALTH CARE CENT	ED		19	987 HILTON ROAD		
				В	URLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (X) (EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DA DEFICIENCY)		
F 600	Continued From page	23	F 6	500			
	licensed nurses and r 1/12/23, by the DON of included Nursing polic Aide, and other inform Education included: "Provision of eme by the situation to any experiencing an accio "A licensed nurse obtain vitals, monitor vital signs, pulse ox e "In the case of bu positioning, rescue br oxygen "Providing emerge accidents/incidents as breathing, control bleac cleansing wounds/app fractures. "Notification to ph as possible. "Contacting EMS "Assuring that lice until EMS arrives, cor and intervene as need "Completion of do incident Education began for a neglect began on 01/ development coordina information regarding as referenced in admi	or designee. Education by 1110-Emergecy First nation noted below. Argency first aide as indicated yone in the center lent or incident. will assess injured persons, patient for changes. Obtain tc. as condition warrants. rn, protect airway, such as eathing, CPR, emergency ency first aide for other is needed-CPR, Rescue eding, emergency oxygen, olying dressing, immobilizing ysician/Next of Kin as soon while staff attend resident tinue to monitor, assess ded cumentation related to the all staff on abuse and 13/2023 by staff ator. Education included types of abuse and neglect inistrative policy 704.			 Address what measures will be put in place or systemic changes made to ensure that the deficient practice will not recur; The Director of Nursing, Staff Development Coordinator will monitor to include reviewing of all newly hired state assure that they have received training abuse and neglect and have successful completed a posttest with acceptable passing scoring weekly x 4 weeks, bi-weekly x 1 month then monthly x 1 month. The Administrator is responsible for the entire plan of correction. Indicate how the facility plans to monitor its performance to make sure the solutions are sustained; The Administrator or Designee will be responsible for reporting information for the audits to the Quality Assurance Performance Improvement (QAPI) committee for recommendations and/o modifications until a pattern of compliant is achieved. The Administrator is responsible for the entire plan of correction. Date of completion: 2/6/2023 	o f to for illy hat om	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/2023 MAPPROVED D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`,		E CONSTRUCTION		LETED
		345420	B. WING				C 17/2023
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANO	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	B ATE	
F 600	designee. The Staff I will be responsible for require education. Ar education will not be a education is received will be educated by th Coordinator on this pe added to the orientation Development was not 01/12/2023. The DON or designee understanding of the discussion and feedba this on a tracking tool in orientation. Nursing staff will com the education provide Coordinator is respon- monitoring the post te initiated on 01/13/202 Date of immediate jeo 14, 2023 Person responsible for the Administrator On 01/17/23, the facil immediate jeopardy re record review of the in which discussed the N Emergency First Aid, multiple staff interview was provided by the I discussed accidents/i of burns), assessment	Development Coordinator tracking staff that still my staff that has not received allowed to work until . All new hire licensed staff the Staff Development blicy. This education will be on process. Staff ified of this responsibility on e will verify the education through oral ack with all staff and notate . The SDC will also do this plete a post- test based on d. Staff Development sible for the post test and est results. The post test is 3. opardy removal is January or implementation the plan is ity's credible allegation for emoval was validated by n-services and sign in sheet	F	600			

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			()(0)	E CONCERNICION	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
				С	
		345420	B. WING		01/17/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ALAMANC	E 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIO
F 600	Continued From page	e 25	F 600		
		communication; and an		-	
	interview with the Adr	ninistrator which indicated			
		g and Staff Development			
		mandatory education for all nediate jeopardy removal			
	date of 1/14/23 was of				
F 684	Quality of Care		F 684	4	2/6/23
SS=J	CFR(s): 483.25				
Ċ	§ 483.25 Quality of ca				
		ndamental principle that nt and care provided to			
		ed on the comprehensive			
	-	dent, the facility must ensure			
		treatment and care in			
	accordance with prof				
	care plan, and the res	nensive person-centered			
	•	is not met as evidenced			
	by:				
	Based on record rev			F684	
	0	and Emergency Medical		1. Identify those recipients who have	
	. , .	and staff, paramedic and ws, the facility failed to		suffered, or are likely to suffer, a serior adverse outcome as a result of the	bus
	-	ess of 3rd degree facial burns		noncompliance of provide first aide in	а
	-	ovide continuous monitoring		timely manner	
		signs or assess the resident		Resident #1 no longer resides in the	
		d for nursing or medical		center. On 1/7/23, shortly before 3AM	
		IS arrived. Resident #1 Id third-degree flame burns		Resident #1 was noted in doorway of room as the Night Shift Supervisor was	
		ce, both ears, left chest, left		coming down the hall. She could see	
		m, and back of left hand.		smoke was coming from the room. S	
		outdoor temperature on		began to call his name and as she	
	01/07/23 was recorded			approached him, she could see his ha	
		dent #1 was only wearing d a short sleeve shirt while		was singed. As she got closer, she c his name, and he did not answer as h	
		was described by EMS		head was down. She pushed his head	
	records as being "slo	-		and back and noted his face was mel	

Facility ID: 932930

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/13/20 MAPPROVE O. 0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING			C 01/17/2023		
NAME OF PR	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
ALAMANCE HEALTH CARE CENTER			19	87 HILTON ROAD				
				BL	JRLINGTON, NC 27217			
(X4) ID PREFIX TAG			ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 684	Continued From page	- 26	F 6	0 4				
1 004			FU	04	off notowing to big buyers of food			
		ey arrived, and he was			off referring to his burned face.	on the		
		eathing. EMS personnel ardiopulmonary resuscitation			She immediately closed his door give smoke detector was sounding and the			
		e ambulance. Resident #1			was visible smoke, rescued him fron			
	()	est twice, required intubation,			danger to the nurse's station, immed			
	and became comatos	· · · ·			pulled the fire alarm and called 911 f	-		
		on 01/12/23. This deficient			Emergency Medical Services (EMS)			
	practice occurred for	1 of 3 residents reviewed for			Fire Rescue at 2:56am. While on th	е		
	supervision to preven	nt accidents.			phone with 911, the Night Shift Supe	rvisor		
					assessed respirations and pulse and			
		began on 01/07/23 when the			provided the information to dispatch			
	•	le continuous monitoring by			instructed. The 911 dispatcher aske			
		sident to determine the need			to get him to the front of the building			
	for nursing or medical	Services arrived. Immediate			await pickup. The Night Shift Super instructed the certified nurse aide (C			
		ed on 01/14/23 when the			to take him to the front of the building	,		
		cceptable credible allegation			await EMS at the request of the 911	9.0		
	• •	dy removal. The facility			dispatch. In the meantime, the Nigh	t Shift		
		iance at a lower scope and			Supervisor was asked to stay on the			
	severity level of "D" (I	No actual harm with potential			phone with the dispatcher. However	, the		
		I harm that is not immediate			nurse did not provide instruction to the			
	,	completion of education and			certified nurse aide as to what to do			
	monitoring systems p	out into place are effective.			this resident; she didn t assess what			
	The findings included	l:			resident needed and failed to render emergency care to maintain Resider			
	-				1⊡s airway.			
		nitted to the facility on			During the wait for EMS to arrive, the			
		e diagnoses which included			states she and other staff watched h			
	Chronic Obstructive F				took his pulse, and she and other sta			
		ripheral vascular disease,			continued to speak to him and touch	nım		
	heart failure, and toba	acco use.			to reassure him knowing he was	h <i>u</i>		
	A physician's order de	ated 12/29/22 indicated			unresponsive. His body was severe slumped over in the chair at his torso	•		
		aceive oxygen at 4 liters per			The CNA notes on interview that she			
		nula every day and night			other staff handed him off to EMS up			
	shift.				their arrival at 3:02am. They dismiss			
					themselves when EMS took over.			
	The admission nursin	ng assessment dated			In review of this incident, the nurse a	ind		
		esident #1 was cognitively			staff assigned to him after he left the			

Facility ID: 932930

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/202 FORM APPROVE OMB NO. 0938-039
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345420	B. WING		C 01/17/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE
ALAMANO	E 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	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE IENCY)
F 684	Continued From page	e 27	F 68	34	
	intact and required su chair/bed-to-transfers	upervision with		failed to monitor and as who had been through suffering multiple burns	a traumatic event
		ignated to be a Full Code. entation of vital signs		him fully to know what i medical needs he had, resident to promote bre	nursing and did not position the
		#1's electronic medical		cover the resident in 37 outside, and did not pro necessary services unt	/-degree weather ovide basic
	Supervisor in the electron Resident #1 dated 01	ten by the Night Shift ctronic medical record of I/07/23 at 3:15 AM stated, esponsive and breathing in		The nurse further sent with an unlicensed staff unable to monitor him v per policy.	him to the lobby f member who was
	to face and hair. Tran and called 911. Instru- to front of building by	W/C [wheelchair] with burns nsferred to nurses' station ucted by 911 to bring resident EMS and transferred care		2. Specify the action the alter the process or sys	stem failure to
		iducted with the Night Shift 23 at 10:30 AM. Night Shift		prevent a serious adver occurring or recurring, a action will be completed	and when the
	Supervisor stated at a she was sitting at the heard "an annoying b later discovered it was	about 3:00 AM on 01/07/23 nurses' station when she peeping sound," which she is the room's smoke detector		Education began for nu include licensed nurses assistants on 1/12/23, t designee. Education in	and nursing by the DON or ncluded Nursing
	she walked down the gray smoke coming f She yelled "I know yo	to investigate the noise. As hall, she saw and smelled rom Resident #1's room. ou're not smoking!" to he reached Resident #1,		policy 1110-Emergecy I other information noted included: "Provision of emerg indicated by the situation	below. Education Jency first aide as
	she saw him in the do upright, with his head and noticed Resident	down. She lifted his head t 41's face and hair severely thing, and unresponsive. She		center experiencing an incident. " A licensed nurse w persons, obtain vitals, r	accident or vill assess injured
	described his facial b melted off." She imm into the hallway via h	urns as "it was like his face ediately brought Resident #1 is wheelchair and closed the		changes. Obtain vital s as condition warrants. " In the case of burn	signs, pulse ox etc. , protect airway,
	-	n to the nurses' station, and called 911. She stated		such as positioning, res CPR, emergency oxyge	

Facility ID: 932930

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/17/2023	
		345420	B. WING			
NAME OF PR	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	987 HILTON ROAD		
ALAMANC	E HEALTH CARE CENT	ER	E	BURLINGTON, NC 27217		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 28	F 684			
	to the front of the built phone. She instructed to push Resident #1 to She stated she had of pulse and respirations the rate. She stated h breathing was norma indicate to other staff because she was wo other residents. A review of the video 01/07/23 revealed Re assisted outside by th Resident #1 was in a his chest to his knees sides of the wheelcha Once outside, two of away. One staff mem Resident #1. One staff the side, returned to I down, looked at Resi and intermittently tou staff members exited past Resident #1. Re the wheelchair, slouc knees, and arms dan wheelchair, limp, with arrived. He did not ha provide protection fro temperature.	nree staff members. wheelchair, slouched, with s, and arms dangling off the air, limp, with no movement. the staff members stepped		 Providing emergency first aid other accidents/incidents as need Rescue breathing, control bleedir emergency oxygen, cleansing wounds/applying dressing, immol fractures. Notification to physician/Next as soon as possible. Contacting EMS Assuring that licensed staff a resident until EMS arrives, contin monitor, assess and intervene as Completion of documentation to the incident. Any nursing staff member that did receive education on 1/12/23 will education by the beginning of the shift by the DON or designee. Th Development Coordinator will be responsible for tracking staff that require education. Any staff that received education will not be allo work until education is received. / hire licensed staff will be educate Staff Development Coordinator of policy. This education will be add orientation process. Staff Develop was notified of this responsibility 01/12/2023. The DON or designee will verify t understanding of the education th oral discussion and feedback with 	led-CPR, ig, bilizing t of Kin ttend ue to needed. n related d not receive next ie Staff still has not owed to All new d by the n this ed to the oment on	
		degrees Fahrenheit on		and notate this on a tracking tool. SDC will also do this in orientation Nursing staff will complete a post	The n.	

Facility ID: 932930

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OLIVIER	S FOR MEDICARE &				OMB NO. 0938-039		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				C			
		345420	B. WING		01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 684	Continued From page	e 29	F 684				
r 004	Resident #1 on 01/07 fire alarm sound and nurses' station, she w Shift Supervisor to br outside front of the br saw Resident #1's inj "his skin was peeled burned on the side." given other instruction Supervisor regarding #1. She further stated she provided Resided protect him from the temperature. Nurse #1 was intervie PM. She indicated sh Resident #1 on 01/07 was dependent on on was not on the floor w She went to the front was notified by other had burned himself w When she had arrive EMS had already arr she saw Resident #1 was unresponsive. S #1 because EMS had interview, she stated Resident #1 for a pul when he was outside took his pulse and re noted his breathing w was strong and within she could not remem	7/23. She responded to the when she arrived at the vas instructed by the Night ing Resident #1 to the uilding. She indicated she juries and described them as off his face and his hair was She indicated she was not ns from the Night Shift providing aid to Resident d she could not remember if nt #1 with a covering to 29-degree Fahrenheit ewed on 01/22/23 at 2:58 ne was assigned to work with 7/23 and knew Resident #1 cygen. She indicated she when the incident occurred. of the building because she staff members Resident #1 while smoking a cigarette. d at the front of the building, ived. She indicated when , his head was down, and he he did not assess Resident d already arrived. Later in the the first time she checked se and respirations was e front of the building. She spirations manually and vas shallow and his pulse n normal range. She stated iber the pulse or respiration she was not provided any	F 684	 Development Coordinator is responsition the post test and monitoring the present results. The posttest is initiated of 01/13/2023. 3. Address what measures will be purplace or systemic changes made to ensure that the deficient practice will recur; The Director of Nursing or Designee monitor all newly hired staff to assure they have received training for delive emergent care and have successfully completed a posttest with acceptable passing scoring weekly x 4 weeks, bi-weekly x 1month then monthly x 1 month. 4. Indicate how the facility plans to monitor its performance to make sure solutions are sustained. The administrator or designee will be responsible for reporting to the Qualit Assurance Performance Improvemer (QAPI) committee for recommendatic and/or modifications until a pattern of compliance is achieved. The Administrator is responsible for the entire plan of correction. 5. Date of completion: 2/06/2023 	ost n t into not will t that ring f		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING				C 17/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALAMANO	CE HEALTH CARE CENT	ER			987 HILTON ROAD SURLINGTON, NC 27217		
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ULD BE COMPLETION	
F 684	Continued From page	30	F	584			
	She indicated she wa Resident #1 on 01/07 care needs, and knew She stated she had c prior to the incident. So outside of the building when the incident occ saw Resident #1 after was outside on the st Documentation of the Services (EMS) report 3:01 AM, EMS arrived sitting in a wheelchair the facility. Resident # slouched/slumped ov was immediately ask breathing and if the re nursing staff respond EMS personnel, again breathing and if he ha nursing staff did not c noted all nursing staff resident, the resident nor was treatment ad prior to EMS arrival. E assessed the resident not be breathing or ha asked the nursing staff information and pape responded with "we d the patient, and there get you that information nursing staff continue doors of the facility.	Emergency Medical t dated 01/07/23 revealed at d on scene. Resident #1 was c outside of the front door of #1 was noted to be er in the wheelchair. Staff ed if the resident was esident had a pulse. The ed, "he's unconscious." n, asked if the resident was ad a pulse, "to which the heck the patient." EMS t had no hands on the was not being assessed, ministered by nursing staff EMS personnel quickly t. The resident was found to ave a pulse. EMS personnel ff about Resident #1's rwork, and the staff on't know anything about is a fire, so we can not [sic]					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 03/13/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345420	B. WING			C 01/17/2023	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z		-	
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 PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIAT IENCY)		(X5) COMPLETION DATE
F 684	in front of the facility. he was breathing. The around Resident #1; H hand their hands on F members were either around. He further inco not report if Resident pulse. He also stated provide him Resident medical conditions. W #1 it was determined pulse or respirations. to the stretcher via 2- cardiopulmonary resu in the ambulance. The Emergency Roor presented to the hosp burns covering Resident well as clavicle and sl of body surface area, Emergency Room ph Resident #1 was sittir on via nasal cannula cigarette that explode burns to the face, neo Resident #1 was note without a pulse so CF CPR was performed for pulse and blood press went into cardiac arre and was intubated aft pressure returned for	23 at 12:29 PM. The	F 684				

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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:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		345420	B. WING			C 01/17/2023		
NAME OF P	ROVIDER OR SUPPLIER			ę	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N SHOULD BE COMPLETIN E APPROPRIATE DATE		
F 684	A review of the Burn A Unit (ICU) hospital no Resident #1 was critic second- and third-deg sides of his face, both arm, left forearm, and his body. It was noted cardiac arrest twice a respiratory failure sec (excess fluid in the lui An interview with the conducted on 01/09/2 Resident #1 was com speak, and had an ar injury caused by a co brain). Resident #1's from Full Code to Do The ICU Physician As 01/10/23 at 12:32 PM reported to her that R the facility and caugh unresponsive and ren admission to the ICU injuries were consisted oxygen. The ICU Attending Pf 01/11/23 at 9:39 AM time of the call, Resid injury (brain injury wh oxygen to the brain) a He was intubated, in a unresponsive. She im- full recovery and a pa be placed due to Res	Attending Intensive Care the dated 01/07/23 revealed cally ill and sustained gree flame burns to both n ears, left chest, left upper I back of left hand to 5.5% of d that he also went into s well has having acute condary to pulmonary edema ngs) and aspiration. ICU Nurse #1 was 23 at 3:02 PM. She indicated hatose, intubated, unable to noxic brain injury (a brain mplete lack of oxygen to the code status was switched Not Resuscitate (DNR). esistant was interviewed on l. She indicated it was esident #1 was smoking at t fire. He was found to be nained unresponsive since burn unit. She stated his ent with smoking while on hysician was interviewed on via phone revealed at the lent #1 had an anoxic brain ich occurs due to lack of and had a poor prognosis.	F	684				

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	-	ID HUMAN SERVICES				FORM	/ APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES	(X2) MUI	(X2) MULTIPLE CONSTRUCTION			0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '				PLETED
						С	
		345420	B. WING			01/	17/2023
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANCE HEALTH CARE CENTER					1987 HILTON ROAD		
					BURLINGTON, NC 27217		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IY	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	F	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIA	HE APPROPRIATE	
					DEFICIENCY)		
E 00.4		••					
F 684	Continued From page		F	684	4		
		PM. She indicated Resident					
	placed on comfort cal	Il condition. Resident #1 was					
		t expected to recover, and					
	death was imminent.	······································					
		PM the ICU Receptionist					
	on 01/12/23 at 5:15 P	indicated Resident #1 died					
	011 0 1/ 12/23 at 5.15 F	IVI.					
	The Director of Nursir	ng (DON) was interviewed					
		PM. She stated she received					
		mber around 3:00 AM on					
		of Resident #1 sustaining					
		a cigarette while on oxygen.					
		I not see Resident #1 when ility as he had already been					
		therefore, she was unable					
		1. She indicated she felt the					
		opriately to the emergency.					
		s notified of immediate					
	jeopardy on January	11, 2023, at 7:35 PM.					
	The facility provided t	he following credible					
		ate jeopardy removal:					
	-						
		nts who have suffered, or					
		serious adverse outcome as					
	a result of the noncor	npliance, and					
	On 1/7/23, shortly bet	fore 3AM, Resident #1 was					
		his room as the Night Shift					
		ng down the hall. She could					
		coming from the room. She					
	•	e and as she approached					
		s hair was singed. As she					
	-	his name, and he did not /as down. She pushed his					
	head up and back and	-					

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C 345420 B. WING 01/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD	391		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C A. BUILDING C 345420 B. WING 01/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD	OMB NO. 0938-0391		
345420 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/17/2023 1987 HILTON ROAD 1987 HILTON ROAD			
345420 B. WING 01/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD			
BURLINGTON, NC 27217			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	ON		
DEFICIENCY)			
F 684 Continued From page 34 F 684			
"melted off" referring to his burned face.			
She immediately closed his door given the smoke			
detector was sounding and there was visible			
smoke, rescued him from danger to the nurses			
station, immediately pulled the fire alarm and called 911 for Emergency Medical Services			
(EMS) and Fire Rescue at 2:56am. While on the			
phone with 911, the Night Shift Supervisor			
assessed respirations and pulse and provided the			
information to dispatch as instructed. The 911			
dispatcher asked her to get him to the front of the			
building to await pickup. The Night Shift Supervisor instructed the certified nurse aide			
(CNA) to take him to the front of the building to			
await EMS at the request of the 911 dispatch. In			
the meantime, the Night Shift Supervisor was			
asked to stay on the phone with the dispatcher.			
However, the nurse did not provide instruction to			
the certified nurse aide as to what to do for this			
resident; she didn't assess what the resident			
needed and failed to render emergency care to maintain Resident # 1's airway.			
During the wait for EMS to arrive, the CNA states			
she and other staff watched him, took his pulse,			
and she and other staff continued to speak to him			
and touch him to reassure him knowing he was			
unresponsive. His body was severely slumped over in the chair at his torso. The CNA notes on			
interview that she and other staff handed him off			
to EMS upon their arrival at 3:02am. They			
dismissed themselves when EMS took over.			
In review of this incident, the nurse and staff			
assigned to him after he left the unit failed to			
monitor and assess Resident #1 who had been through a traumatic event suffering multiple			
through a traumatic event suffering multiple burns, did not assess him fully to know what			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	<i>I</i> APPROVED 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED	
		345420	B. WING	-			C 17/2023	
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
				1	1987 HILTON ROAD			
ALAMANCE HEALTH CARE CENTER			E	BURLINGTON, NC 27217				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
F 684	nursing and medical r position the resident in 3 and did not provide ba EMS arrived. The nu lobby with an unlicens unable to monitor him policy. Specify the action the process or system fai adverse outcome from when the action will b Education began for r licensed nurses and r 1/12/23, by the DON of included Nursing polio Aide, and other inform Education included: o Provision of eme by the situation to any experiencing an accid o A licensed nurse obtain vitals, monitor vital signs, pulse ox e o In the case of but positioning, rescue br oxygen o Providing emerge accidents/incidents as breathing, control blea cleansing wounds/app fractures. o Notification to ph as possible. o Contacting EMS o Assuring that lice	heeds he had, did not o promote breathing, did not 30 degree weather outside, asic necessary services until rse further sent him to the sed staff member who was a which was required per the entity will take to alter the lure to prevent a serious in occurring or recurring, and e completed. hursing staff to include hursing assistants on or designee. Education by 1110-Emergency First nation noted below. rgency first aide as indicated yone in the center	F	684				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 03/13/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE	
		345420	B. WING			01/	C 17/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	01/	11/2023
					1987 HILTON ROAD		
ALAMANO	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	and intervene as need o Completion of do incident Any nursing staff mer education on 1/12/23 beginning of the next designee. The Staff I will be responsible for require education. Ar education will not be a education will not be a education is received will be educated by th Coordinator on this po added to the orientation Development was not 01/12/2023. The DON or designeed understanding of the discussion and feedba this on a tracking tool in orientation. Nursing staff will com the education provide Coordinator is respon monitoring the post te initiated on 01/13/202 Date of immediate jeo 14, 2023 Person responsible for the Administrator On 01/17/23, the facili immediate jeopardy re	ded becumentation related to the mber that did not receive will receive education by the shift by the DON or Development Coordinator r tracking staff that still ny staff that has not received allowed to work until . All new hire licensed staff ne Staff Development olicy. This education will be on process. Staff tified of this responsibility on e will verify the education through oral ack with all staff and notate . The SDC will also do this plete a post- test based on ed. Staff Development isible for the post test and est results. The post test is	F	684			

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		СОМРІ	
		345420	B. WING			01/*	17/2023
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ALAMANO	CE 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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIOI DATE
F 684	on the facility's Nursin First Aid and education including the case of notification, and effect	aled they received education ng Policy - 1110 Emergency on on situation of accidents	F	684			
F 689 SS=J	education was provid and Staff Developme jeopardy was remove Free of Accident Haz	ed by the Director of Nursing nt Coordinator. Immediate ed on 01/14/23. ards/Supervision/Devices (2)	F	689			2/6/23
	The facility must ensu §483.25(d)(1) The re- as free of accident ha §483.25(d)(2)Each re- supervision and assis accidents.						
	Based on record rev review, Emergency M review, and staff, faci transportation driver, transportation compa Captain, hospital staf the contracted facility failed to notify the fac observed to be smok his wheelchair, was in lighter, and repeated cigarettes and coffee	facility's contracted iny's owner, fire department f, and Paramedic interviews, r transportation company cility Resident #1 was ing with an oxygen tank on n possession of cigarettes, a ly asked the driver to stop for while en route to a			F689 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance; and Resident #1 no longer resides in the center. Resident # 1 was taken to an appointment by a transportation compa on January 6th. The transportation drive failed to communicate with the facility th Resident # 1 was observed by the transportation driver smoking with an	ny er	
	lit a cigarette in his ro sustained second- ar	ent. On 1/07/23 Resident #1 oom with oxygen in use and nd third-degree flame burns nce, both ears, left chest, left			oxygen tank present on his wheelchair and was observed in possession of smoking materials. The transportation driver failed to notify the facility that		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/13/202 MAPPROVE D. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345420	B. WING _				C / 17/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
ALAMANO	CE HEALTH CARE CENT	TER			987 HILTON ROAD URLINGTON, NC 27217		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	Continued From pag	e 38	F	589			
		rm, and back of left hand.			Resident #1 had requested numerou	IS	
	EMS personnel imme				times during the transportation to sto		
		uscitation (CPR) once inside			purchase smoking materials. As a re		
		vent into cardiac arrest twice,			on 1/7/23, shortly before 3AM, reside		
		ecame comatose. Resident			was noted in doorway of his room as		
		23. This is evidenced for 1 of			Night Shift Supervisor was coming d		
		for supervision to prevent #1). In addition, the facility			the hall. She could see that smoke coming from the room. She began t		
		a resident as safe to smoke			his name and as she approached hi		
		after he was non-compliant			she could see his hair was singed.		
	with the facility's smo	-			she got closer, she called his name,		
		or supervision to prevent			he did not answer as his head was o		
	accidents (Resident	#2).			She pushed his head up and back a		
	Immodiate iconardy/	began on 01/06/23 when the			noted his face was melted off referring his burned face.	ng to	
		nsportation company failed			All residents that are transported to		
		esident #1 was smoking with			appointments by a transport compar	iv and	
		le back of his wheelchair,			residents that are not compliant with		
		cigarettes, a lighter, and			smoking policy have the potential to	be	
		ng the driver to stop for coffee			affected by this deficient practice.		
	-	en route to a physician's			2. Specify the action the entity will ta		
		iate jeopardy was removed			alter the process or system failure to prevent a serious adverse outcome		
	on 01/17/23 when the	allegation for immediate			occurring or recurring, and when the		
		ne facility remains out of			action will be completed.		
		er scope and severity level of			Education began on 1/7/23, for all st	aff in	
	"D" (No actual harm	with potential for more than			all departments by Staff Development		
		not immediate jeopardy) to			Coordinator Education included:		
		f education and monitoring			The smoking policy, including but no	t	
	systems put into plac	ce are effective.			limited to:	od co	
	Example #2 for Resid	dent #2 was cited at a scope			 Those patients currently assess deemed independent vs supervised 		
	and severity of "D".				safety for smoking and supervised		
					smoking times as indicated on the		
	The findings included	1:			updated smoking list which was revi	sed	
	1. The hospital disch				on 1/7/23 and is available at all nurs	•	
		esident #1 is to place one 21			stations. The Director of Nursing was	5	
		ne patch on the skin daily			responsible for updating the list of		
	(reason unspecified)	as well as to utilize oxygen			supervised smokers on 1/7/23 and v	/111	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/13/2023 FORM APPROVEL OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345420	B. WING		C 01/17/2023
NAME OF PI	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP	•
ALAMANO	CE HEALTH CARE CENT	ER		1987 HILTON ROAD BURLINGTON, NC 27217	
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	DF CORRECTION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE COMPLETION D THE APPROPRIATE DATE
F 689	Continued From page	e 39	F 68	39	
		y was also ordered (reason		update smoking list as ne o Monitoring patient be activity in room related to	ehavior and
	12/29/22 with multiple Chronic Obstructive F	nitted to the facility on e diagnoses which included Pulmonary Disease, ripheral vascular disease,		combustible materials on reporting it to the charge supervisor for follow-up. o Monitoring changes i	nurse and/or
	heart failure, and toba	-		patients that previously w in the center, but who ma desire to smoke, and repo	y express a
	private room.			charge nurse and/or supe follow-up.	ervisor for
	Resident #1 to utilize	ated 12/29/22 revealed oxygen at 4 liters per minute ery day and night shift.		o Immediately notifying and/or Director of Nursing occurrence for any reside	g at the time of
		ated 12/29/22 staff is to pipe		smoking out of the design area. Consequences of s	nated times and
	oxygen into Resident device that helps with	#1's BiPAP machine (a breathing which pushes air		oxygen on can result in so o Nurse management	erious injury. (director of
		night shift and as needed for n levels and shortness of		nursing, assistant director managers and/or staff de coordinator) will remove a	velopment
		ated 12/29/22 stated apply		that did not receive the ed schedule until education i	ducation from the is completed.
		rams Nicotine patch kin) one time a day for 6 weeks and remove per		The staff development co responsible for tracking th received the required train	nat staff have
	schedule.			working their next shift. A employees will be educat	Il future ed by staff
	one 24- hour 14 millig	ated 12/29/22 stated apply grams Nicotine patch skin) one time a day for		development coordinator in-services during new hin Current staff have receive	re orientation.
		r 2 weeks and remove per		The Staff Development C tracking this information t works that have not recei	o ensure no staff
	one 24-hour 7 milligra	ated 12/29/22 stated apply ams Nicotine patch skin) one time a day for		education. o Education began on nurses, discharge planne	1/7/23 for all
		r 2 weeks and remove per		completion of the smoking	

Facility ID: 932930

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	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/203 MAPPROVE D. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345420	B. WING _				C 17/2023	
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•		
ALAMANC	E HEALTH CARE CENT	ER			987 HILTON ROAD URLINGTON, NC 27217			
				ы	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE	
F 689	Continued From page	e 40	F	89				
	schedule.				and discussion of the smoking			
					acknowledgement with all new			
	The admission nursir	ng assessment dated			admissions by the DON, SDC or			
		esident #1 was cognitively			designee, including discussions with			
	intact and required su	•			patients who state they are not a curre	ent		
	chair/bed-to-transfers	5.			smoker but have a history of smoking,			
	The Smelling Sefety	Screen dated 12/29/22			and education to patients desiring to smoke but who wear oxygen. This			
	completed by the Un				education will be done by the SDC, DC	אר		
	Resident #1 did not s	•			or designee. All disciplines were education			
		n by the Unit Manager on			on their responsibility on 01/09/2023.			
	- -	stated "Resident stated that			new admissions will be discussed duri			
	he has not had a ciga	arette in 2 months and did			morning clinical meeting with the			
		smoke. Writer made resident			disciplines and updates on progress o	f		
	aware that he will be	on nicotine patches."			assigned task.			
	Decident #1's core pl	lan datad 01/02/22 indicated			Anyone working after 1/7/23 who has received the education will not be allow			
	Resident #1 is at risk	an dated 01/03/23 indicated			to work. This education will also be do			
	complications due to				in orientation beginning of 1/7/23, for a			
	Pulmonary Disease,				new hire nurses and new hire member			
	•	en requirement and Bilevel			the IDT. Staff Development Coordinate	or		
		sure machine (a machine			will track and ensure education is			
		into lungs and opens			provided. Staff Development Coordina	tor		
		s for Resident #1 to be free			was notified of this responsibility on			
		plications through the review			1/07/2023.	_		
	period. Interventions	included: administer ed; administer nebulizer			o All smoking assessments and car			
		d; administer oxygen as			plans for current smokers were review and updated by the Interdisciplinary Te			
		d, administer oxygen as dered; observe for signs and			(IDT) to assure appropriateness of	an		
		ory complications; and vitals			supervised vs. unsupervised smoking			
	as needed.	· ·			status. This was completed by the			
					Director of Nursing or designee on 1/7			
		as interviewed on 01/09/23 at			o All new admissions for the last 30			
		ated she completed Resident			days will be reviewed for evidence of a	a		
		2/29/22 and was familiar with			smoking assessment and their	-		
		s admitted directly from the			completion, as well as the care plan for			
	-	was cognitively intact during completed the Smoking			anyone desiring to smoke by 1/8/23 by DON or designee.			
		dicated Resident #1 does			o On 1/8/23 all residents □ POC Ka	dov		

Facility ID: 932930

		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 03/13/202 M APPROVE D. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		345420	B. WING			C / 17/2023
NAME OF PI	ROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZIP COD)E	
				1987 HILTON ROAD		
ALAMANO	CE 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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 689	Continued From page	o 11	F 68			
1 003			F 08			
		ed Resident #1 indicated he		were updated to reflect smok		
		e and had no desire to		designation as supervised sm		
		icility. She reviewed the cy and Resident #1 voiced		unsupervised smoker, or hist smoking. The resident Point of		
		e completing his admission,		Kardex is seen on the Certifie		
		y smoking materials in		Assistance kiosk where daily	-	
		ssions. She did not recall		review and documentation is		
		ving friends or family visit him		certified nursing assistants ea	-	
		he indicated she was aware		Education began on 1/7/23, f		
	-	ng policy that all smoking		all departments by Staff Deve		
	materials are to be ke	ept at the nurses' station until		Coordinator Education includ	ed:	
	ready to be used and	l smoking materials should		" All current patients that s		
	not be kept in resider	nt's rooms.		received re-education of the	•	
				policy, smoking acknowledge		
	An interview with the	-		current smokers and all new		
	-	on 01/10/22 at 4:43 PM		re-reviewed and completed o	-	
	-	esident #1 up in the morning		the discharge planning direct		
		port him to a physician's		designee. The smoking policy		
		nt #1 frequently asked for		smoking materials will not be	kept in the	
		e store to purchase coffee he was transporting Resident		patient room. " For all current smokers a	and all now	
	#1 to his physician's			admissions, the discharge pla		
		I not stop and proceeded to		designee will educate respon		
		's office. He stated when		parties/emergency contacts of		
		#1 after his physician's		providing and delivery of smo		
		nt #1 was outside of the		materials to the charge nurse	-	
		an elevator lift, and smoking		keeping. The discharge planr		
		kygen tank on the back of his		this task by going over the sn		
	wheelchair. He told F	Resident #1 he could not		and having the resident or res	sident	
	smoke while on oxyg	en or while in the		representative sign the smok	-	
	-	e requested Resident #1 to		acknowledgement. Any new		
		Resident #1 agreed to stop		that arrives with smoking mat		
	•	ne cigarette off the side of		have their smoking materials		
		lift is a platform that is used		properly stored in secure area	•	
		eelchairs to the level of the		discharge planners. Discharg	e planners	
	- - ,	vay back to the facility,		contacted all emergency		
	-	ed to stop for a cup of		contacts/responsible parties a	•	
		Resident #1 that he could		verbal education on smoking		
	not make any additio	nal stops. He stated he		specifically delivery of smokir	ig materials	

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						D. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	. ,	E SURVEY PLETED
			A. BUILDING	3		С
		345420	B. WING			
	ROVIDER OR SUPPLIER	0.0.120		STREET ADDRESS, CITY, STATE, Z		/17/2023
	KOWDER OR SOLT EIER			1987 HILTON ROAD		
ALAMAN	E HEALTH CARE CENT	ER		BURLINGTON, NC 27217		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE , CROSS-REFERENCED DEFICI	TO THE APPROPRIATE	COMPLETIO DATE
F 689	Continued From page	e 42	F 68	39		
		ions to the owner of the		and storage. This will be	e completed on	
	•	ansportation company.		01/16/2023.		
				" To ensure that smo	king materials are	
		erview on 01/10/23 at 1:21		returned for all smokers		
		acted transportation driver		assisted from smoking p		
	reiterated Resident #			smoking materials are p		
		arrived. Resident #1 had a lit		designated locked and s		
		The cigarette was about d Resident #1 that he could		smoking attendant is as the smoking area 8a-8p	0	
	not smoke in the van			on the daily nursing staf		
		and put the cigarette out by		communicate what staff	-	
		ide of the elevator lift.		assigned. The facility so	heduler will be	
	-			responsible for assuring		
	An additional intervie	w with facility's contracted		assignment sheet notate	es what staff is	
		was conducted on 01/11/23		assigned each shift as s	-	
		n, stated when he arrived to		The smoking attendant		
	pick Resident #1 fron			smoking material when	-	
		It #1 was smoking a lit		from the smoking area.		
		gen tank on the back of his #1 had a package of		attendant will distribute material when the reside	-	
		er in his hands. He told		smoke. Between the ho		
		could not smoke with oxygen		resident, who is deemed		
		ansportation van. He stated		would like to smoke a si		
		nderstanding and put the		will be assigned individu	-	
	cigarette out.			distribute the resident th	eir smoking	
				materials and at the end		
		AM with the owner of the		session retrieve smokin	-	
		ansportation company		returned to proper stora		
		d not notify him of his		current safe/unsupervise		
		dent #1 smoking or asking er the nursing home facility		educated on this proces of Nursing or designee I		
		ation on 01/07/23. He stated		1/14/23 and this educati		
	-	ed him of the observations,		by the Staff Developmen		
	he would have notifie	-		The smoking attendant		
		-		unsupervised smokers a		
				collect their smoking ma	aterials. Education	
		Scheduler at the physician's		began to all staff on the	-	
		on 01/10/23 at 2:15 PM.		process by the Director		
	She stated Resident	#1 sat in the lobby until		designee on 01/14/2023	3 on the	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TID	PLE CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	. ,	IPLETED
						С
		345420	B. WING		0	1/17/2023
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIF		
				1987 HILTON ROAD		
ALAMAN	CE 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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 689	Continued From page	- 12				
1 003			F 68		alvin a attain da nt	
	-	She assisted Resident #1 or then the transportation		responsibilities of the sm location of assignment sh	U	
		or then the transportation van.		appropriate storage of sn		
		not recall Resident #1		Any staff that have not re	•	
		lighter visible when she		education will not be allow		
	assisted Resident #1	0		they have received the re	equired	
				education.		
	The nursing note writ	ten by the Night Shift		" On 1/7/23 all smoki	ng residents⊡	
	Supervisor in the elec	ctronic medical record of		rooms and persons were	searched with	
		/07/23 at 3:15 AM stated,		consent by Director of Nu	-	
		sponsive and breathing in		manager and all smoking		
		W/C [wheelchair] with burns		confiscated and placed b		
		sferred to nurses' station		doors. Unit manager prov		
		Icted by 911 to bring resident		to smokers on risks of ha		
	to EMS."	EMS and transferred care		materials in room and on Unsupervised smokers v	-	
				understanding of this poli		
	An interview was con	ducted with the Night Shift			j .	
		23 at 10:30 AM. Night Shift				
	Supervisor stated at a	about 3:00 AM on 01/07/23				
		nurses' station when she				
		beeping sound," which she				
		from the room's smoke		The Staff Development C		
		to investigate the noise. As		provide the education in	-	
		hall, she saw and smelled		third-party vendor on 1/1		
		rom Resident #1's room.		communicate the written		
	She yelled "I know yo	he reached Resident #1,		two transportation compa the facility and all drivers	•	
		porway of his room, sitting		for the facility. Education		
		I down. She lifted his head		by our third-party entity w		
		#1's face and hair severely		administrative oversite fo	•	
		hing, and unresponsive. She		transportation vendors fo		
		urns as "it was like his face		Nursing and Rehabilitation		
		ediately brought Resident #1				
	into the hallway via h	is wheelchair and closed the		Any driver not educated		
		n to the nurses' station,		allowed to transport resid		
		and called 911. She stated		center until education has		
		escort Resident #1 to the		The third-party entity will		
	front of the building a	nd to stay on the phone. She		with the center that the tr	ansportation	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 03/1 FORM APPF OMB NO. 0938	ROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		345420	B. WING		C 01/17/202	23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMP	X5) PLETION ATE
F 689	She stated she never his room and Resider smoking. Additional interview w Supervisor was cond AM. Resident #1 was not a fire actively bur was wearing clothes started, and a gray bu floor. When she appr could smell burned fle and long beard were all the way up to one remember which ear An interview with NA revealed she was not Resident #1 on 01/07 she was not familiar never worked with hin the fire alarm when s Night Shift Superviso front. Documentation of the Services (EMS) repoid 3:01 AM, EMS arriver sitting in a wheelchait the facility. Resident a slouched/slumped ov was immediately ask breathing and if the re nursing staff respond EMS personnel, agai breathing and if he has nursing staff did not of	know Resident #1 smoked. r saw smoking materials in nt #1 never asked about with the Night Shift ucted on 1/10/23 at 10:44 a not on fire and there was ning. She stated Resident #1 when the incident had urned shirt was found on the oached Resident #1, she esh and hair. His long hair burned unevenly including of his ears. She could not was burned. #1 on 01/09/23 at 3:36 PM t assigned to work with 7/23. She further indicated with Resident #1 and had m. She was responding to he was instructed by the r to take Resident #1 to the e Emergency Medical rt dated 01/07/23 revealed at d on scene. Resident #1 was r outside of the front door of #1 was noted to be rer in the wheelchair. Staff	F 68	9 companies have been educated education will be tracked by the Development Coordinator. Dranot complete the education of will not be allowed to transport center until education is receins Staff Development Coordinated designee will educate all server ambassadors and the in-house transportation coordinator on education received by the transportation received by the transportation received by the transportation scheet at the front desk will verify with that reports to pick up a resided received the required education the facility to check out the for the transport. When a new transportation driver is hired the company verification of educate forwarded from the third-party facility for tracking of required the transportation driver is hired to company verification of educate forwarded from the third-party facility for tracking of required the transportation company drive staff Development Coordinator and appointment scheduler will be on 01/13/2023 on the same it transportation company drive staff Development Coordinator 3. Address what measures will be place or systemic changes mensure that the deficient pracarecur; Administrator or designee will	he Staff ivers that did in 1/13/23, it for the ved. The or or ice se the written insportation is for tion on sadors and duler, located h any driver ent has on by asking e facility. juired come he resident v by the ation will be v entity to the d facility e educated ems as the rs by the or ill be put into ade to tice will not	

Facility ID: 932930

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		MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDING	i		
		345420	B. WING			С
		545420		STREET ADDRESS, CITY, STATE, ZIP CODE	0'	/17/2023
NAME OF P	ROVIDER OR SUPPLIER					
ALAMAN	CE HEALTH CARE CEN	TER		1987 HILTON ROAD BURLINGTON, NC 27217		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETIO DATE
F 689	Continued From pag	e 45	F 68	9		
	resident, the residen	t was not being assessed,		reviewing facility in-service she	et for new	
		dministered by nursing staff		driver signature which will inclu		
		EMS personnel quickly		of any newly hired transportation		
		nt. The resident was found to		assure that they have received		
	-	ave a pulse. EMS personnel		required education at the facilit		
		aff about Resident #1's		completion of the questionnaire	9	
	information and pape			Education to the transportation	drivere	
		don't know anything about e is a fire, so we can not [sic]		Education to the transportation service ambassadors, facility a		
		ion." It was noted that		scheduler will include.	ppointment	
		ed to enter and exit the front		Safety concerns would include	e but not be	
	doors of the facility.			limited to unbuckling, attempts		
				attempts to smoke, known smo		
	An interview was cor	nducted with the responding		vaping.	•	
	paramedic on 01/11/	23 at 12:29 PM. The		" Type of concerns to report	-behaviors,	
		nen he arrived, he saw		unusual requests for stops,		
	-	d over in a wheelchair outside		noncompliance with safety dire		
		ilding. Resident #1 did not		during transport. This will be pa		
		athing. There were staff		ongoing orientation process for		
		sident #1; however, no staff ands on Resident #1. He		transportation vendors to use in orientation process.	i their	
		s were either on their phones		" Returning the resident to f	acility and	
		le further indicated staff		drop off procedure to include re		
	-	eport if Resident #1 was		concerns to Service Ambassad		
		ulse. He also stated facility		service ambassador is located	at the front	
		provide him Resident #1's		desk at the front door. The serv	/ice	
		or medical conditions. When		ambassador is located at the fr		
		nt #1 it was determined		from the hours 8am- 8pm. If the		
		have a pulse or respirations.		transportation driver returns wh		
		essed to the stretcher via		service ambassador is not available abarge pures for the patient will		
	resuscitation (CPR)	and cardiopulmonary		charge nurse for the patient will by the transportation driver. Ed		
	. ,	er indicated Resident #1's		provided to the Service Ambas		
		nd not opened as well has		Charge Nurses by the Staff De		
		ns on face and charring on		Coordinator is listed below		
	his nose.			o Any concerns noted by Se	ervice	
				Ambassador will be immediate		
	Documentation of the	e Fire Department report		the charge nurse, unit manage		
	dated 01/07/23 revea	aled at 3:03 AM the fire		supervisor for follow up. The se	ervice	

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	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	I Y	ATE SURVEY DMPLETED
		345420	B. WING _				C
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		01/17/2023
					B7 HILTON ROAD		
ALAMAN	CE HEALTH CARE CENT	ER			JRLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 689	Continued From page	e 16	F 6	20			
1 000			Г C	009	ambaaaadar is the front deals attendar	.+	
		n scene. The location of the nt #1's room. Upon arrival to			ambassador is the front desk attendar Education will be provided to current	IL.	
				-			
	the room, they found			service ambassadors by Staff Development Coordinator on 01/13/20	123		
		inside of the room was light to moderate smoke and found no fire. After gathering information			Any service ambassador will not be at		
		and investigating, it was			to work until they have received education		
		ent occurred due to Resident			by the staff development coordinator.		
		smoke a cigarette while on					
		hich contributed to ignition			o Charge Nurses will be educated b	ov	
	was "misuse of mate				Staff Development Coordinator on wh		
					the appropriate steps to take when		
	An interview was cor	iducted with the responding			receiving report from transportation dr	iver	
	Fire Department Captain on 01/11/23 at 10:42				or service ambassador. Education will		
	AM. He stated EMS			include implementation of appropriate			
	arrival and was atten	ding to Resident #1. When			interventions, updating care plans and	ł	
	he investigated the fi			notifying medical provider as needed.			
		ell as powder from a fire			" Transportation drivers, service		
	U U	ced a gray shirt on the floor			ambassadors and charge nurses that	are	
	with burns. He furthe	r indicated there was melted			not scheduled to work 01/13/2023 will		
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	d on the floor as well. He			receive education before their next		
		ned Resident #1 had a			scheduled shift. Staff Development		
		nd was attempting to smoke			Coordinator is responsible for the		
	while on oxygen.				education and ongoing monitoring of t	he	
					education.		
		m hospital records dated			This will be conducted weekly x4 wee	eks,	
		esident #1 presented to the			bi-weekly x 4 weeks then monthly x1		
		hickness burns covering nd neck as well as clavicle			month.		
		timately 10% of body surface			4. Indicate how the facility plans to monitor its performance to make sure	that	
		nostrils. The Emergency			solutions are sustained:	uial	
		ed EMS reported Resident #1			The administrator or designee will be		
		hair with oxygen on via nasal			responsible for reporting of the finding	is to	
	-	osequently lit a cigarette that			the Quality Assurance Performance	5.0	
		causing severe burns to the			Improvement (QAPI) committee for		
		s, and clavicle. Resident #1			recommendations and/or modification	s	
		sponsive, without a pulse so			until a pattern of compliance is achieve		
		EMS. CPR was performed			Ther Administrator is responsible for the		
	-	his pulse and blood pressure			plan of correction.		
		1 went into cardiac arrest					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/13/2023 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345420	B. WING _					
	ROVIDER OR SUPPLIER	ER		19	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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	his pulse and blood p second time. Due to h hospital initiated a tra A review of the Burn A Unit (ICU) hospital no Resident #1 was critic second- and third-deg sides of his face, both arm, left forearm, and his body. It was noted cardiac arrest twice a respiratory failure sec (excess fluid in the lu An interview with ICU on 01/09/23 at 3:02 F #1 was comatose, int and had an anoxic br caused by a complete brain). Resident #1's from Full Code to Do The ICU Physician As 01/10/23 at 12:32 PM reported to her that R the facility and caugh unresponsive and rer admission to the ICU injuries were consisted oxygen. The ICU Attending Pf 01/11/23 at 9:39 AM time of the call, Resic injury (brain injury wh oxygen to the brain) a	utes and was intubated after pressure returned for the his significant burns, the insfer to a local burn unit. Attending Intensive Care bute dated 01/07/23 revealed cally ill and sustained gree flame burns to both in ears, left chest, left upper d back of left hand to 5.5% of d that he also went into is well has having acute condary to pulmonary edema	F	589	5. Date of completion: 2/6/2023			

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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 COMP	SURVEY PLETED
		345420	B. WING			OMB NO. (X3) DATE S COMPL C 01/1	0 17/2023
NAME OF P	ROVIDER OR SUPPLIER				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 SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	unresponsive. She interview of a particul recovery and recover	dicated she did not expect a illiative care consult would ident #1's poor prognosis. I Nurse #2 was conducted PM. She indicated Resident il condition. Resident #1 was re with no aggressive it expected to recover, and PM the ICU Receptionist indicated Resident #1 died PM. sident #1's room on revealed 5 permanent dark the linoleum tile floor on the hich was located near the ark was approximately 5" is approximately 4" x 3", one f x 2", and two were . The areas felt rough to the ed on 01/10/23 at 10:25 AM. is assigned to work with i/23, was familiar with his v he was oxygen dependent.	F	689			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/13/2023 MAPPROVED). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED	
		345420	B. WING		_		C 17/2023	
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
ALAMANO	E HEALTH CARE CENT	ER		987 HILTON ROAD BURLINGTON, NC 272'				
(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 689	Continued From page	: 49	F 689					
		urther stated Resident #1						
	1:11 PM revealed she Resident #1's room. S Resident #1 smoked.	She stated she did not know She never saw smoking and he never asked her						
	at 2:15 PM. He stated Resident #1. He introd #1 a week before the #1 if he was a smoker being a smoker. He s about the smoking po education to Resident which included safe n wearing oxygen and s	as interviewed on 01/09/23 I he was familiar with duced himself to Resident incident. He asked Resident r, and Resident #1 denied tated Resident #1 knew licy. He further provided t #1 regarding oxygen safety nobility in the room while smoking while on oxygen. vided to all residents who						
	on 01/09/22 at 1:57 P a call from a staff mer 1/07/22 notifying her of injuries from lighting a She indicated she did she arrived at the faci taken by ambulance; to assess Resident # staff responded appro When she investigate gray burned shirt on t marks on linoleum tile saw approximately 6 f tubing. There was a li	ng (DON) was interviewed M. She stated she received mber around 3:00 AM on of Resident #1 sustaining a cigarette while on oxygen. not see Resident #1 when lity as he had already been therefore, she was unable 1. She indicated she felt the opriately to the emergency. d the room, she noticed a he floor as well as 5 burned e flooring. Additionally, she to 10 feet of melted oxygen ghter located under the terminal Air Conditioner						

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/13/2023 // APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	
		345420	B. WING				C 17/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1987 HILTON ROAD		
ALAMAN	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	(PTAC) unit and a page an animal cracker page missing. She threw the the oxygen tubing. She had thrown these item Smoking Safety Screet admission, quarterly, changed their mind all the charge nurse or the the Smoking Safety S completed Resident # She did not know whe smoking materials. The Administrator was jeopardy on January for The facility provided the allegation for immedia Identify those recipient are likely to suffer, a se a result of the noncom Resident # 1 was take transportation driver for the facility that Resided transportation driver for Resident #1 had requi during the transportation smoking materials. As before 3AM, resident his room as the Night coming down the hall, was coming from the	ckage of cigarettes hidden in ckage with one cigarette e gray shirt away as well as the did not indicate why she his away. She stated the ensiver completed at and whenever a residents bout smoking. She indicated he unit manager completes creen. The Unit Manager et's Smoking Safety Screen. ere Resident #1 obtained is notified of immediate 12, 2023, at 5:43 PM. The following credible ate jeopardy removal: the who have suffered, or serious adverse outcome as inpliance; and en to an appointment by a my on January 6th. The ailed to communicate with ent # 1 was observed by the smoking with an oxygen tank chair and was observed in g materials. The ailed to notify the facility that ested numerous times ion to stop and purchase is a result, on 1/7/23, shortly #1 was noted in doorway of	F	68			

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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 LETED		
		345420	B. WING				C 17/2023		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>			
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPLE			
F 689	his hair was singed. A his name, and he did down. She pushed h noted his face was "m burned face. All residents that are by a transport compa compliant with smokin to be affected by this Specify the action the process or system fai adverse outcome from when the action will b Education began on a departments by Staff Education included: The smoking policy, in o Those patients of deemed independent smoking and supervise indicated on the upda revised on 1/7/23 and stations. The Director for updating the list of 1/7/23 and will update o Monitoring patier room related to havin self and reporting it to supervisor for follow-to o Monitoring change patients that previous center, but who may of and reporting this to t supervisor for follow-to o Immediately notif	As she got closer, she called not answer as his head was is head up and back and helted off" referring to his transported to appointments ny and residents that are not ng policy have the potential deficient practice . e entity will take to alter the lure to prevent a serious n occurring or recurring, and e completed. 1/7/23, for all staff in all Development Coordinator ncluding but not limited to: urrently assessed as vs supervised for safety for sed smoking list which was i is available at all nursing of Nursing was responsible f supervised smokers on e smoking list as necessary. It behavior and activity in g combustible materials on o the charge nurse and/or up. ges in the condition of ly were non-smoking in the express a desire to smoke, he charge nurse and/or	F	689	9				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		345420	B. WING				C 17/2023			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
ALAMANO	E HEALTH CARE CENT	ER			987 HILTON ROAD BURLINGTON, NC 27217	CORRECTION (X5)				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE			
F 689	smoking with oxygen injury. o Nurse managem assistant director of n and/or staff developm any employee that did from the schedule und The staff developmen for tracking that staff I training prior to workin employees will be edu coordinator on the ab hire orientation. Curr education. The Staff I tracking this informati that have not received o Education began discharge planners ar smoking assessment smoking acknowledge admissions by the DC including discussions are not a current smo smoking, and educati smoke but who wear be done by the SDC, disciplines were educ on 01/09/2023. All ne discussed during mor the disciplines and up assigned task.	moking out of the area. Consequences of on can result in serious ent (director of nursing, ursing, unit managers nent coordinator) will remove d not receive the education til education is completed. At coordinator is responsible have received the required ng their next shift. All future ucated by staff development ove in-services during new ent staff have received this Development Coordinator is on to ensure no staff works d the education. on 1/7/23 for all nurses, nd IDT on completion of the and discussion of the ement with all new DN, SDC or designee, with patients who state they ker but have a history of on to patients desiring to oxygen. This education will DON or designee. All ated on their responsibility w admissions will be ning clinical meeting with dates on progress of	F	589						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391		
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		345420	B. WING				C / 17/2023		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE				
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217	OF CORRECTION			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 689	nurses and new hire i Development Coordir education is provided Coordinator was notif 1/07/2023. o All smoking asse current smokers were the Interdisciplinary Tr appropriateness of su smoking status. This Director of Nursing or o All new admission be reviewed for evide assessment and their care plan for anyone by the DON or design o On 1/8/23 all resi updated to reflect sm supervised smoker, ut history of smoking. Th Kardex is seen on the Assistance kiosk whe documentation is don assistants each shift. Education began on departments by Staff Education included: All current patients th re-education of the sr acknowledgements for new admits were re- 1/8/23 by the discharg designee. The smokin materials will not be k	members of the IDT. Staff hator will track and ensure . Staff Development fied of this responsibility on essments and care plans for e reviewed and updated by eam (IDT) to assure upervised vs. unsupervised was completed by the designee on 1/7/23. ons for the last 30 days will ence of a smoking completion, as well as the desiring to smoke by 1/8/23 hee. idents' POC Kardex were oking designation as unsupervised smoker, or he resident Point of Care e Certified Nursing are daily resident review and he by the certified nursing	F	689	9				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION		LETED			
		345420	B. WING				C 17/2023			
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	FE, 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 SC 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 689	proper providing and materials to the charg The discharge planner going over the smokin resident or resident re- smoking acknowledge that arrives with smok smoking materials tak secure area by the dis planners contacted al contacts/responsible education on smoking of smoking materials completed on 01/16/2 To ensure that smokin all smokers, residents patio by staff and smo the designated locked smoking attendant is smoking area 8a-8p a nursing staffing sheet member is assigned. responsible for assuri sheet notates what st smoking attendant. The collect smoking materials from the smoking area will distribute the smo resident goes to smol 8p-8a, if a resident, we smoker would like to swill be assigned individ distribute the resident and at the end of the smoking materials to storage location. All of	mergency contacts on delivery of smoking ge nurse for safe keeping. er performs this task by ng policy and having the expresentative sign the ement. Any new admission king materials will have their ken and properly stored in scharge planners. Discharge I emergency parties and provided verbal g policy specifically delivery and storage. This will be 2023. In g materials are returned for a re assisted from smoking obing materials are placed in d and secured location. A assigned to monitor the and will be noted on the daily is to communicate what staff The facility scheduler will be ng that the assignment aff is assigned each shift as he smoking attendant will rial when they return inside a. The smoking attendant king material when the ke. Between the hours of tho is deemed a safe smoke a smoking attendant idually as needed to a their smoking materials smoking session retrieve	F	689						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE			
		345420	B. WING				C 1 7/2023		
NAME OF P	ROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE				
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217	N, NC 27217			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 689	Director of Nursing or 1/14/23 and this educ Staff Development Co attendant will supervis and distribute and col Education began to a process by the Direct 01/14/2023 on the res attendant, location of appropriate storage o staff that have not rec be allowed to work ur required education. On 1/7/23 all smokin persons were searche of Nursing and Unit m materials were confis locked doors. Unit ma smokers on risks of h room and on person. verbalized understand The Staff Developme the education in writin on 1/13/23 who will the education to the two to utilized by the facility. drive for the facility. E our third-party entity to oversite for all transport Alamance Nursing an Any driver not educate transport residents fro has been received. The communicate with the	a designee beginning on cation will be tracked by the pordinator. The smoking se all unsupervised smokers lect their smoking materials. Il staff on the new smoking or of Nursing or designee on sponsibilities of the smoking assignment sheet, and f smoking materials. Any ceived this education will not not till they have received the g residents' rooms and ed with consent by Director nanager and all smoking cated and placed behind anager provided education to aving smoking materials in Unsupervised smokers ding of this policy. In Coordinator will provide of to the third-party vendor nen communicate the written ransportation companies and all drivers assigned to aducation will be provided by who provides administrative ortation vendors for id Rehabilitation. ed will not be allowed to om the center until education he third-party entity will e center that the nies have been educated.	F	689					

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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	(X3) DATE COMP	SURVEY PLETED		
		345420	B. WING				C 17/2023		
NAME OF P	ROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>			
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ACTION SHOULD BE COM TO THE APPROPRIATE			
F 689	Development Coordir complete the education allowed to transport for is received. The Staff or designee will educa- and the in-house trans the written education transportation compa- verifying and providin The service ambassa transportation schedu will verify with any driver resident has received asking the driver whe Transportation drivers facility to check out the When a new transpor company verification of forwarded from the the for tracking of require The service ambassa appointment schedule 01/13/2023 on the sat transportation compan Development Coordir Education to the trans ambassadors, facility include. Safety concerns wout to unbuckling, attemp smoke, known smokin o Type of concerns unusual requests for st	hator. Drivers that did not on on 1/13/23, will not be or the center until education Development Coordinator ate all service ambassadors sportation coordinator on received by the nies and responsibilities for g education on 1/13/23. dors and in-house ller, located at the front desk ver that reports to pick up a the required education by n they enter the facility. s are required come into the e resident for the transport. tation driver is hired by the of education will be ird-party entity to the facility d education. adors and facility er will be educated on me items as the ny drivers by the Staff nator. sportation drivers; service appointment scheduler will ld include but not be limited ts to stand, attempts to ng or vaping. to report-behaviors, stops, noncompliance with ng transport. This will be part	F	68	9				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			C
		345420	B. WING				17/2023
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	process. o Returning the resp procedure to include in Service Ambassador. located at the front de service ambassador in from the hours 8am-8 driver returns when the not available, the chan be notified by the transe Education provided to and Charge Nurses by Coordinator is listed by o Any concerns not will be immediately gin manager or supervised ambassador is the from Education will be provided ambassadors by Staff on 01/13/2023. Any side be able to work until the education by the stafff o Charge Nurses w Development Coordinator appropriate steps to the from transportation driverses charge nurses that ar 01/13/2023 will receiven next scheduled shift.	s to use in their orientation sident to facility and drop off reporting concerns to The service ambassador is esk at the front door. The s located at the front desk Bpm. If the transportation he service ambassador is rge nurse for the patient will isportation driver. to the Service Ambassadors y the Staff Development below bed by Service Ambassador ven to the charge nurse, unit or for follow up. The service ont desk attendant. vided to current service f Development Coordinator service ambassador will not hey have received d development coordinator. vill be educated by Staff nator on what the ake when receiving report iver or service ambassador. implementation of ons, updating care plans provider as needed. s, service ambassadors and e not scheduled to work re education before their Staff Development sible for the education and the education.	F	689			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345420 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 01/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE F 689 Continued From page 58 F 689		-	ND HUMAN SERVICES				FORM	M APPROVED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 345420 B. WING 01/17/2023 NAME OF PROVIDER OR SUPPLIER ALAMANCE HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES BURLINGTON, NC 27217 (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID SUMMARY STATEMENT OF DEFICIENCIES IDENTIFYING INFORMATION) (X4) ID DEFICIENCY MUST BE PRECEDED BY FULL COMPLETING INFORMATION) A. BUILDING COMPLETED COMPLETED COMPLETED COMPLETION SHOULD BE DEFICIENCY OF LSC IDENTIFYING INFORMATION) A. BUILDING COMPLETED COMPLETED COMPLETED COMPLETED COMPLETION SHOULD BE DEFICIENCY OF LSC IDENTIFYING INFORMATION) A. BUILDING COMPLETED COMPLETED COMPLETED COMPLETED COMPLETION SHOULD BE DEFICIENCY OF LSC IDENTIFYING INFORMATION) A. BUILDING COMPLETED COMPLETION DATE DEFICIENCY COMPLETED COMPLET				(X2) MU					
C 345420 C 01/17/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALAMANCE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON ROAD BURLINGTON, NC 27217 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE				· ,					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ALAMANCE HEALTH CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (X5) COMPLETION DATE					-			С	
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 PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE			345420	B. WING			01/	17/2023	
ALAMANCE HEALTH CARE CENTER BURLINGTON, NC 27217 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	NAME OF PF	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE			
ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	ALAMANCE HEALTH CARE CENTER					1987 HILTON ROAD			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE					I	BURLINGTON, NC 27217			
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE					v				
							CROSS-REFERENCED TO THE APPROPRIATE		
F 689 Continued From page 58						DEFICIENCY)			
F 689 Continued From page 58									
	F 689	Continued From page	∋ 58	F	689				
Demonstration of the state of the state		Dama an an an aible fa							
Person responsible for implementation of the plan is Administrator.			or implementation of the plan						
On 01/17/23, the facility's credible allegation for		On 01/17/23, the facil	lity's credible allegation for						
immediate jeopardy removal was validated by									
record review of the Activity Reporting			• • •						
Procedures document related to residents' transportation which included smoking, vaping,									
and signed by five contracted transportation		-							
drivers; staff interviews of educated regarding									
smoking safety with supervised and unsupervised									
smokers, location of combustible materials,									
location of smoking designation area, reporting									
smoking concerns, and consequences of		-	-						
smoking with oxygen; interview with the Administrator which indicated the Director of									
Nursing provided education to staff, smoking									
residents received re-education on the smoking			-						
policies and the Staff Development Coordinator		policies and the Staff	Development Coordinator						
educated third-party transportation company									
drivers; and an interview with the facility's			-						
contracted transportation driver indicated he									
received re-education related to activity during transportation. The immediate jeopardy was									
removed on 01/17/23.		· ·							
2. The facility's Smoking Policy dated 10/24/22		-							
indicated "the Center promotes a smoke-free environment to protect the health, safety, and									
well-being of all our patients; therefore, the									
Center maintains a policy of no smoking within									
the building by anyone at any time." Procedures									
included "the Administrator will designate areas		included "the Adminis	strator will designate areas						
outside of the building for any smoking activities;"		-							
"a patient may smoke in designated smoking									
areas: if the patient has been assessed by the interdisciplinary team and it has been determined									

Facility ID: 932930

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391		
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED		
		345420	B. WING				C / 17/2023		
NAME OF P	ROVIDER OR SUPPLIER		•	;	STREET ADDRESS, CITY, STATE, ZIP CODE				
ALAMAN	CE HEALTH CARE CENT	ER			1987 HILTON ROAD BURLINGTON, NC 27217	IC 27217			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 689	through the Smoking for the patient to smo that cause a spark or will be kept in a locke electronic delivery sys Resident #2 was adm 08/03/22 with diagnos stenosis, muscle weat high blood pressure, I due to stroke. The quarterly Minimu 12/01/22 revealed Re mildly impaired. He re with transfers, dressir hygiene. Resident #2's most re 12/12/22 revealed a fr resident prefers to sm stated the resident wi review period. Interve to be educated on the smoke independently smoke; and complete needed. The Smoke Safety So indicated Resident #2 any cognitive loss, ha problems. He underst place at designated ti must be returned to a facility staff when not safe to smoke withou	Safety Screen that it is safe ke;" and "all instruments a flame (igniting products) d location, as well as any stems." hitted to the facility on ses that included spinal kness, difficulty in walking, eft sided muscle weakness m Date Set (MDS) dated sident #2's cognition was equired extensive assistance ng, toilet use, and personal ecent care plan dated ocus area indicating the noke cigarettes. The goal II smoke safely through the intions included Resident #2 e facility smoking policy; may ; signed all consent to smoking assessment as ereen dated 08/11/22 e smoked and did not have d no visual or dexterity tood smoking may only take mes; smoking accessories nd kept under control of the in use. He was labeled as t supervision.	F	689					

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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:		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		345420	B. WING			C 01/17/2023			
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
ALAMANO	E 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 689	policy. This note was Resident #2 nor his ro oxygen. Resident #2 oxygen source at the Nurse #3 was intervie PM. She indicated sh with Resident #2 but when she smelled cig entered the room, she cigarette in a cup. She lighter away from Res him on the smoking p The Smoke Safety So indicated Resident #2 any cognitive loss, ha problems. He underst place at designated ti must be returned to a facility staff when not safe to smoke without A behavior nursing no AM revealed Residen smoking inside the bu lighter was taken from re-education was prov designated area to sm tolerated intervention room. This note was of	were locked in the dent #2 agreed to the re-educated on the smoking documented by Nurse #3. commate had an order for was not within 15 feet of an time of the incident. wed on 01/11/23 at 4:02 e was not assigned to work was walking by the room arette smoke. When she e saw Resident #2 drop the e took the cigarette and sident #2 and re-educated olicy. creen dated 12/05/22 e smoked and did not have d no visual or dexterity tood smoking may only take mes; smoking accessories nd kept under control of the in use. He was labeled as t supervision. the dated 12/26/22 at 3:08 t #2 was found to be hilding at 2:45 AM. The n Resident #2 and wided to him on the noke and times. Resident #2 and was escorted back to documented by Nurse #2.	F	689					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 03/13/2023 // APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345420	B. WING			C 01/17/2023	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
				.	1987 HILTON ROAD		
	CE HEALTH CARE CENT	ER		1	BURLINGTON, NC 27217		
(X4) ID PREFIX TAG			ID PREFI TAG				(X5) COMPLETION DATE
F 689	PM revealed she was care needs. She indic Resident #2 smoking, him actively smoking. her to "come get your cigarette." She could Resident #2 was smo inside of the building, designation area door Resident #2, she did smelled cigarette smo her the cigarette box of re-educated on the sr receptive to education to giving her the cigar indicated she might he Manager of this incide the incident in the phy Resident #2 was inter PM. He stated he was smoking policy and ha designated smoking a Smoking Acknowledg past and he should ke at the nurses' station. nurses if he can smok the two incidents regat the facility. The Unit Manager wa 4:16 PM. She stated s Safety Screen, she si watches them light the cigarettes, and put out	se #2 on 01/11/23 at 3:27 familiar with Resident #2's rated another nurse found but Nurse #2 did not see She stated the nurse told patient. I think he just lit a not recall who told her king. Resident #2 was in the in front of the smoking rs. When she approached not see him smoke, but oke. He did not want to give or lighter. He was noking policy and was n in which he was receptive ettes and lighter. She ave notified the Unit ent and might have written visician communication book. viewed on 01/09/23 at 1:25 s aware of the facility's ad to smoke in the area. He said had signed a ement agreement in the eep his cigarettes and lighter He said he had to ask the are and was unable to recall arding him smoking within s interviewed on 01/11/23 at she completed the Smoking esident #2 on 08/11/22 and she conducts a Smoking ts down with the resident, e cigarettes, smoke the	F	689	9		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 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 01/17/2023			
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-			
				1	1987 HILTON ROAD				
ALAMANO	E HEALTH CARE CENT	ER		BURLINGTON, NC 27217					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	(X5) COMPLETION DATE				
F 689	complete Smoking Sa resident harmed them stated an additional S would not have been found smoking outsid area because she sor if they are safe to smo stated Resident #2 re smoking policy and w unsupervised smoker remained an safe, un- he could light a cigare independently. The Director of Nursir on 01/09/23 at 1:57 P Safety Screens are et admission, quarterly, changed their mind al the charge nurse, or t the Smoking Safety S completed Resident # and she is responsible resident is safe to sm Review of the Ad Hoo Performance Improve 12/05/22 revealed the resident was found sr cause analysis deterr possession of a lighter plan included: offendi re-educated on safe s current smokers woul policies and procedur staff would implement	d. She indicated she would afety Screens as needed if a neelves while smoking. She safety Smoking Screen warranted if a resident was e of the designated smoking reens residents to determine oke unsupervised. She ceived re-education on the as deemed a safe, . She indicated Resident #2 supervised smoker because ette, smoke it, and put it out hg (DON) was interviewed 'M. She stated the Smoking xpected to be completed at and whenever a resident bout smoking. She indicated he unit manager completes Green. The Unit Manager #2's Smoking Safety Screen, e for determining if a oke independently. cuality Assurance and ement documentation dated e problem indicated a moking in room. The root nined resident was found in er in their room. The action ng resident would be smoking within the facility; d be re-educated on es related to appropriate d matches; administrative t daily rounding focused on	F	689					
	changed their mind al the charge nurse, or to the Smoking Safety S completed Resident # and she is responsible resident is safe to sm Review of the Ad Hoc Performance Improve 12/05/22 revealed the resident was found sm cause analysis determ possession of a lighter plan included: offendi re-educated on safe s current smokers woul policies and procedur storage of lighters and staff would implement	bout smoking. She indicated the unit manager completes Green. The Unit Manager #2's Smoking Safety Screen, e for determining if a oke independently. Cuality Assurance and ement documentation dated e problem indicated a moking in room. The root mined resident was found in er in their room. The action ng resident would be smoking within the facility; d be re-educated on res related to appropriate d matches; administrative							

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	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 03/13/2023 FORM APPROVED MB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
345420		B. WING _			C 01/17/2023			
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	I	011112020	
ALAMANO	CE HEALTH CARE CENT	ER			TON ROAD			
				BURLIN	GTON, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION E DATE	
F 689	Continued From page matches; current smo Interdisciplinary Team smokers continue to b facility; and any smok be removed and plac nurses' station. The A and Performance Imp	e 63 okers had been reviewed by n (IDT) to assure current be safe to smoke at the cing materials found would ed in secure locations on ad Hoc Quality Assurance provement documentation 8/22 to indicate Resident #2	F	89				

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