PRINTED: 08/04/2023 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COMPLETED
		345261	B. WING		C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	1 01/12/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	0	
F 580 SS=J	through 06/28/23. Th 07/12/23 of additional identified after manage. Therefore, the exit day The following intakes NC00198878, NC00198878, NC00198878, NC00200744, NC00201966, NC00203167,	199134, NC00200667, 200929, NC00201337, 202380, NC00203068, 203752. Intake NC00203167 sulted in immediate jeopardy. Investigations resulted in a F607. Was identified at: at scope and severity of J. at scope and severity J. at scope and severity of J. constituted Substandard began on 02/16/23 and was B. A partial extended survey sijury/Decline/Room, etc.) 4)(i)-(iv)(15) cation of Changes.	F 58	0	8/3/23
	(i) A facility must imm consult with the resid consistent with his or representative(s) who (A) An accident invol	nediately inform the resident; lent's physician; and notify, her authority, the resident			
ARODATORY	DIDECTOR'S OR BROWNER	SLIPPLIER REPRESENTATIVE'S SIGNATUR		TITLE	(X6) DATE

Electronically Signed 08/03/2023

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	, ,	DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	,	01112/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	mental, or psychosod deterioration in heal status in either life-t clinical complication (C) A need to alter the aneed to discontinuteratment due to addommence a new for (D) A decision to transident from the faresident information is available and prophysician. (iii) The facility must resident and the resident and the resident and the resident and the resident from the faresident and the resident fare in §483. (B) A change in root as specified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483. (B) A change in root as pecified in §483.	on; inge in the resident's physical, ocial status (that is, a th, mental, or psychosocial chreatening conditions or s); reatment significantly (that is, is an existing form of verse consequences, or to orm of treatment); or insfer or discharge the cility as specified in diffication under paragraph (g) in, the facility must ensure that tion specified in §483.15(c)(2) wided upon request to the stalso promptly notify the ident representative, if any, or or roommate assignment in 10(e)(6); or dent rights under Federal or ons as specified in paragraph in. it record and periodically (mailing and email) and	F 58				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY IPLETED
		345261	B. WING			С
		345261	B. WING_		•	7/12/2023
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
ALI FGHA	NY CENTER			179 COMBS STREET		
ALLEGIIA	III OLIIILK			SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From pag	ne 2	F 5	80		
		een its different locations				
	under §483.15(c)(9)					
	•	T is not met as evidenced				
	by:	is not met as evidenced				
	•	views and staff and Physician		F580 Notify of Changes		
		/ failed to notify the Medical		1 000 1 Totally of Orlanges		
	Director when a resi			1. Resident #9 no longer r	resides at this	
		te change in condition on		facility.	coldee at time	
		ed by Nurse Aide (NA) #3 as				
		or, struggling to breathe, and		2. Current residents with a	acute changes	
		continence and as described		in condition have the potent	-	
	by NA #4 as restless	s and up and down all night		affected by this deficient pra		
	for 1 of 1 resident re	viewed for notification of				
	change. A few hours	later Resident #9 was found		3. DON and ADON have of	completed	
	slumped over in his	wheelchair in cardiac arrest.		education for all licensed sta	aff including	
	Resident #9 expired	in the facility on 06/13/23.		full-time, part-time, PRN and on the importance of notifyir		
	Immediate jeopardy	began on 06/13/23 when		resident⊡s physician when	-	
		nced an acute change in		presents a change in condit		
	condition and Nurse	#2 failed to notify the		when a resident presents di	fferent than	
	physician. Immediat	e jeopardy was removed on		known baseline, lethargic, re	estless or	
	06/23/23 when the f	acility provided and		short of breath. Education v	was also	
		eptable credible allegation of		provided on the use of the o		
		removal. The facility will		system for after hours and o		
	•	iance at a lower scope and		DON or designee will review		
		I harm with more than		report during clinical meeting		
		not immediate jeopardy) to		residents who may have had	-	
	•	systems are in place and the		condition. Licensed staff that		
	completion of staff e	ducation.		received the education will be	•	
	The finding included			have education prior to the i		
	The finding included	i .		worked. Newly hired license receive education in orienta		
	Resident #0 was roo	admitted to the facility on		receive education in offenta	uon.	
		oses that included chronic		4. DON or designee will a	udit 5 resident	
		ry disease, congestive heart		records 5 times per week fo		
		ery disease, atrial fibrillation		then 5 resident records for 3		
	and heart failure.	., L.Joude, anial hormanon		week for 4 weeks, then 5 re	•	
				2 times per week for 4 week		
	The quarterly Minim	um Data Set (MDS)		signs of change of condition		

Facility ID: 923249

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345261	B. WING			1	C 42/2022
NAME OF D	ROVIDER OR SUPPLIER	0.020.		STREET ADDRESS CI	ITY, STATE, ZIP CODE	1 077	12/2023
NAME OF FI	NOVIDER OR SUFFLIER						
ALLEGHA	NY CENTER			179 COMBS STREET			
				SPARTA, NC 2867	'5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	÷ 3	F 5	30			
	assessment dated 04 was cognitively intact	/10/23 revealed Resident #9			reported to the physician needed are put in place.	and	
	A review of Resident revealed the following orders: *04/06/23 Ventolin HF Aerosol Solution 108 Base) 2 puffs inhale of wheezing/dyspnea, g A review of Resident 06/13/23 at 5:07 AM or up and down from his vice versa most of the complaining of pain to but would not take an meds. His bilateral low draining serous sanguliquid part of blood (seamounts. Resident #8 Unna boots (medicate to his legs used to co to allow staff to replace to the inferior of the complaining to the inferior of the infe	#9's medical record g medication and treatment FA (Albuterol) Inhalation micrograms (mcg) (90 orally four times a day for ive with spacer. #9's progress note dated revealed, Resident #9 was a bed to his wheelchair and be night. He was constantly be bilateral lower extremities by physician ordered pain wer extremities were uineous, both blood and the erum), fluid in moderate be had previously cut off his ed dressings/wraps applied antrol swelling) and refused be them. He was I meds and care. Would not ith any care at this time. Will med and or treatment to ith any care at this time. Will med and or treatment to ithes. The note was written #9's progress note dated revealed, Ventolin HFA lution 108 mcg (90 Base) 2 r times a day for ive with spacer inhaler. of was written by Nurse #2.		5. The Direct these audits to Committee me consecutive me Assurance Coeffectiveness make addition recommendat ensure continuation.	ctor of Nursing will bring to the Quality Assurance eeting monthly for three months. The Quality ommittee will evaluate the of the above plan and will interventions and tions based on the audits ued compliance. Impletion August 3, 2023.	ll to	
	A review of Resident Administration Record	#9's Medication d for 06/2023 indicated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		DATE SURVEY COMPLETED
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	ı	07/12/2023
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F 580	Resident #9 refuse 06/13/23 for 6:00 A A review of Resider 06/13/23 at 6:40 Af called to room via s #9 was noted to be wheelchair, non-resin color with no resiplaced on floor and Resuscitation (CPF CPR continued unt deceased at 7:00 Af was written by Nurse Mass written by Nurse #2 the Nurse of Resident #9 abought of 06/12/23 under The Nurse reported oriented and was not medications mainly medicated dressing that his legs were esores and he would off after the nurses explained that Resinght of 06/12/23 to other night, she has stated he was restledown from his bed they found him lying anything unusual a would often put him the Resident compirefused to take pair Nurse #2 continued	d his Ventolin Inhaler on M. Int #9's progress note dated of revealed, the nurse was staff, and upon arrival Resident slumped over in his sponsive to verbal stimuli, blue pirations. Resident #9 was Cardiopulmonary (2) was initiated. 911 was called. In 1911 arrived. Pronounced w.M. MD was notified. The note	F 58			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		345261	B. WING _			C 7/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 179 COMBS STREET SPARTA, NC 28675		7/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	off the wall because that was no change reported if she thou to the hospital she Nurse explained the Resident #9 betwee he was sitting in his and she gave him due at 6:00 AM. Not that during shift charter the oncoming nurse the nurses to come where they found he foot of his room over and nonrespondexplain that she and CPR with the Nurse compressions first. had called 911 and Nurse Educator had called 911 and Nurse again confirm on-call provider sear regarding a change because she did not any change in condition, she would resident #9 expired An interview was condition, she would resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with Resident #9 expired An interview was conditionally at 4:25 Poworked with	e took the phone from him and e he called 911 all the time and e in his behavior. The Nurse light he warranted being sent would have called 911 herself. at she last spoke with en 6:00 AM to 6:20 AM when is wheelchair in the hallway, his Ventolin inhaler which was urse #2 continued to explain ange she was giving report to e when nurse aides yelled for e down to Resident #9's room him sitting in his wheelchair at mate's bed. He was slumped insive. The Nurse continued to did the Nurse Educator initiated e Educator starting the chest Nurse #2 stated someone when the EMS arrived, the did already stopped CPR due to sponding to the CPR. The med that she had not called the rices or the physician e in condition for Resident #9 bot think he had experienced dition. The Nurse stated if she is experienced a change in the late of the Resident the Saturday or in the Resident the Saturday between the Resident the Saturday between the Resident the Saturday prior to the morning of Monday explained that Resident #9 was broughout the shift in that he	F	580		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 501251			Ι,	С
		345261	B. WING			1	12/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	12/2023
	(0.1.52.1.0.1.50.1.2.2.1.				179 COMBS STREET		
ALLEGHA	NY CENTER				SPARTA, NC 28675		
	0.11.11.42.70.4.0	TATELLEN TO DE DESIGNATION			·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC 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 580	Continued From pag	ue 6	F	580			
		s going from his chair then	'	000			
	back to his bed like h	•					
		that earlier in the night he					
		ring on the floor and went to					
	_	A #3 to help him get the					
	_	loor and back into his chair					
	where he always sta	yed. He reported he had					
	never known of the F	Resident to lie in the floor					
	before. The NA expl	ained that the Nurse asked					
	the Resident if he wa	as in pain and the Resident					
		and wanted to stay in the					
	floor where he said was more comfortable for						
		ouragement the Resident					
		s wheelchair. The NA stated e room to continue their					
		n the night Resident #9 turned when the NA answered it the					
	_	n to call an ambulance for					
	him but did not say v						
	_	stated Resident #9 had					
	never asked him to	call an ambulance before that					
	night and he went ar	nd got Nurse #2 for the					
	Resident before the	NA left the room to continue					
		stated that he did not know					
	what transpired betw	veen Resident #9 and Nurse					
		oom, but the NA knew the					
		ambulance for Resident #9					
		ft because the Resident was					
	_	ne NA continued to explain					
	_	ne that morning someone					
	_	ed and asked him if Resident					
		call an ambulance and he he did, and the NA reported					
	to Nurse #2 that the	•					
		it did not say why. The NA					
		known of Resident #9					
		lance or calling for an					
		nor did he observe the					
		se the hall phone to call an					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023	
	NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP COL 179 COMBS STREET SPARTA, NC 28675	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	4:59 PM the NA reportwo NAs that took caroutine basis but the NA #4 was the Residuith his care. NA #3 night NA #4 found hi came and got her an #9 up out of the floor wanted to stay in the into his chair and NA her rounds. NA #3 caround 4:30 AM she call 911 using the ph hallway. When the Na doing the Resident to trouble breathing and hospital. The NA state be struggling to breatimediately went to nurses' desk and told trying to call 911 using stated he was having pale. The NA stated didn't just take the pl the NA told the Nurse and wanted to go to Nurse #2 went to Reto call 911 from the Phone from the Resiasking to go to the himedications here so to do for him then president in the process.	with NA #3 on 06/21/23 at orted that she was one of the ire of Resident #9 on a night of 06/12/23 to 06/13/23 dent's aide and he helped explained that earlier in the m lying on the floor and id Nurse #2 to get Resident The The Resident stated he floor, but they put him back if #3 left the room to continue on tinued to explain that noticed Resident #9 trying to one on the wall in the IA asked him what he was old her that he was having id wanted to go to the ted Resident #9 seemed to the and was pale, so she Nurse #2 who was at the id her that Resident #9 was nig the hall phone and he ig trouble breathing and was the Nurse asked her why she none from Resident #9 and the because he didn't look right the hospital. The NA reported sident #9 who was still trying niall phone and took the dent and told him that he was ospital but he won't take his what was the hospital going occeded to remove the	F 58	30			
	in his wheelchair still to breath. NA #3 stat	Resident #9 sat back down looking pale and struggling and Nurse #2 walked back to lidid not come back to the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 580	AM to 6:00 AM. The Resident #9 was no because he would relike go smoke where room, and he was renight he was incontrated to the NA stated sheet change in behavior NA #4 discussed he different that night. During an interview (DON) on 06/21/23 explained that after 06/13/23 NA #5 inforceported that Resid shift and had tried to phone in the hall but from him and did not condition. She contfound the Resident wheelchair and CPI Resident expired. The information sheet there was no incide fall she reported the and an investigation Nurse #2 should had change in condition. Director for further of the Administrator he learned of the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 investigation of the Resident was compared to the situal morning of 06/13/23 in	ther med pass around 5:45 e NA stated she knew of his usual self that night normally do what he wanted to in he wanted then to go to his normally continent but that inent and had to be changed. was certain she reported his to Nurse #2 because she and ow Resident #9 was acting with the Director of Nursing at 1:15 PM the DON the morning meeting on ormed her that third shift NA #3 ent #9 had fallen during the of call 911 himself by using the at Nurse #2 took the phone of assess him for a change in inued to explain that they slumped over in his R was initiated but the the DON stated that based on was given and the fact that ant report about Resident #9's e situation to the Administrator in was started because they felt are assessed the Resident's and notified the Medical	F 5	30			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3	ODATE SURVEY COMPLETED
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F 580	from him and from 911 himself. The Nithe Resident and country the Resident and country the Resident #9 coded Administrator state negligent in not assin condition and not further guidance in An interview condut Physician on 06/20 was not surprised was not surprised was not surprised was not surprised were necessary to overload which were necessary to overload which were neart failure. While certificate the MD ewent into biventricut that cause the heart prevents oxygen rich brain and body and heart failure related He continued to exwas beating so fast emergency room the survival but regardl medical provider she Resident #9's channel to could be evaluated. The facility provides the facility provides the facility provides.	until Nurse #2 took the phone the wall so that he couldn't call curse should have assessed alled the Medical Director and to report the Resident's and expired. The dhe felt the Nurse was tessing the Resident's change tifying the physician to obtain	F 58			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY OMPLETED	
		345261	B. WING _			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		1 01/12/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	#3 identified Reside color, struggling to be urinary continence. Resident #9 as bein all night long reques There was no notific regarding the change #9. At approximately #6 started their rour be slumped over in called for help. The responded. Upon as Educator determine and did not have a part the floor by the Nursand CNA #6. Chest	eximately 4:30 am Nurse Aide ent #9 as restless, pale in preathe, and a change in Nurse Aide #4 described grestless and up and down enting to go to the hospital. Eation made to the MD er in condition for Resident of 6:40 am CNA #5 and CNA end and discovered resident to wheelchair. At that time, they Nurse Practice Educator essessment the Nurse Practice ed resident was not breathing oulse. Resident was placed on the Practice Educator, CNA #5, compressions were started the Educator after confirming	F 5	80			
	the facility. On 6/22/23 the Nurs residents who have the last 30 days usin 24-hour report was change such as not resident, lethargic, sonset pain, etc. Any this audit will be cor Managers by 6/22/2 Specify the action the process or system fadverse outcome frowhen the action will. The Director of Nurse was a supplied to the second seco	3. ne entity will take to alter the ailure to prevent a serious om occurring or recurring, and					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X5) A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345261	B. WING		C 07/12/2023	
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 79 COMBS STREET PARTA, NC 28675	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 580	following a change Nursing and Assistate ducated Nursing A change in resident of Licensed Nurse immas given on a chawhen a resident prebaseline, lethargic, Furthermore, educause the on-call MD weekends. The Direstaff will work witho Any new hires, inclueducation prior to the responsibility of ensure this is compompleted by 6/22/2 Effective 6/22/2023 responsible to ensure this is compompleted by 6/22/2 Effective 6/22/2023 responsible to ensure this incompleted by 6/22/2 Effective 6/22/2023 responsible to ensure this incompleted. Alleged Date of IJ For On 06/28/23 the factor of the licensed nurses and the last 30 days and by 06/22/23. The number of the licensed nurses notifying the provide conditions. Nurse a identifying a resider anything different for the licensed nurse and the licensed nurse and identifying a resider anything different for the licensed nurse and the licensed nurse and identifying a resider anything different for the licensed nurse and identifying a resider anything different for the licensed nurse and identifying a resider anything different for the licensed nurse and identifying a resider anything different for the licensed nurse and identifying a resider anything different for the licensed nurse and licensed	tification of the Physician of condition. The Director of ant Director of Nursing assistants on identifying a condition and reporting to the mediately. Verbal education ange of condition is noting asents different than known restless or short of breath. Aution was provided on how to system after hours and on actor of Nursing will ensure no out receiving this education. Auding agency staff will receive the start of their shift. It will be the Director of Nursing to leted. Education will be seen the Administrator will be the implementation of this or removal for this alleged.	F 580			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345261	B. WING		C 07/12/2023
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	1 0771272020
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 580	to ensure no staff, fa before being educate The facility's remova validated.	of Nursing will be responsible cility or agency will work ed on the new procedure. I date of 06/23/23 was	F 58		8/3/23
SS=K	CFR(s): 483.12(a)(1 §483.12 Freedom from Exploitation The resident has the neglect, misapproprisand exploitation as concludes but is not lirecorporal punishment any physical or chemical the resident's missing §483.12(a) The facility §483.12(a)(1) Not us physical abuse, corpinvoluntary seclusion This REQUIREMEN by:	om Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from , involuntary seclusion and nical restraint not required to nedical symptoms. ty must- se verbal, mental, sexual, or oral punishment, or a; T is not met as evidenced			
	staff, and Psychiatric interviews the facility right to be free from Resident #11's arms Aide (NA) #10 and the incontinence care who combative. On 02/16 Resident #11 became attempted to pinch, so When Resident #11 facing NA #10, NA #	failed to protect a resident's abuse or mistreatment when were pinned between Nurse		1. Resident #11 and Resident continue to reside in the facility, I #2 no longer resides at the facilit Resident #1 and Resident #11 hapresented with any signs of mentanguish or psychosocial harm rethe reportable incidents. Reside longer resides at the facility. 2. Current residents that encouresident to resident incident have	#1 Resident y. ave not tal lated to nt #9 no

PRINTED: 08/04/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		X3) DATE SURVEY COMPLETED
		345261	B. WING _			C 07/12/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	01/12/2020
				179 COMBS STREET		
ALLEGHA	NY CENTER			SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE. CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE
F 600	Continued From pag	je 13	F 6	00		
F 600	prevent Resident #1 scratching the staff a incontinence care. R have bruises to bilate This was for 1 of 1 re to staff abuse. The female resident (Resfrom a male resident when Resident #2 et and touched her bre of her clothes). NA # touching Resident # alone and unsupervishe went to report th Nurse #1 failed to no sexual abuse. Then again entered Resid touch and kiss her. From Resident #2 touching 1 of 3 residents revie abuse. The facility for resident (Resident #06/13/23 when he exin condition. NA #3 condition as restless breathe, and a change #4 described the change and Nurse #2 Resident #9 and too neglected to call or so of 1 resident reviewer Resident #9 was four wheelchair in cardiace in the facility on 06/1	I from pinching and and so they could finish the desident #11 was noted to eral hands and lower arms. Esident reviewed for resident acility also failed to protect a sident #1) from sexual abuse to (Resident #2) on 03/19/23 intered Resident #1's room ast and vaginal area (outside #1 asked Resident #2 to stop 1 and then left Resident #1 sed with Resident #2 while he sexual abuse to Nurse #1. otify the Administrator of the on 03/20/23 Resident #2 ent #1's room and tried to Resident #1 did not want gor kissing her. This affected ewed for resident-to-resident urther failed to prevent a 9) from being neglected on experienced an acute change described the change in spale in color, struggling to ge in urinary continence. NA ange as restless and up and dent #9 requested and hergency Medical Services are removed the phone from k it off the wall. Nurse #2 seek medical assistance for 1 and slumped over in his coarrest. Resident #9 expired 3/23.	F 6	potential to be affected lattercations and unreporabuse. Current resident changes in condition had be affected by this defice. 3. DON and ADON had education for staff meminal including the various type (verbal, physical, mentation involuntary seclusion, exmisappropriation, resided mistreatment). Education provided on changes of that can indicate abuse presenting with these be changes should be monochange reported to their that have not received the required to have edunext shift worked. Newly receive the preceding erorientation. 4. DON or designee we checks on residents with lower on 5 residents with lower on 5 residents 5 till 4 weeks, then 5 resider week for 4 weeks, then times per week for 4 weeks interviews vanished by the signs of abuse. Administration will conduct interviews vanished by the signs of abuse in the signs of abuse of the signs of abuse. Administration is signed to the signs of abuse of the signs of abuse of the signs of the sig	rted allegations of the with acute ve the potential to itent practice. Ave completed bers on abuse, per of abuse I, sexual, neglect exploitation, ent to resident and the properties of abuse I, sexual, neglect exploitation, ent to resident and the properties of abuse I, sexual, neglect exploitation, ent to resident and the properties of abuse I, sexual, neglect exploitation, ent to resident and the properties of the education will cation prior to the prior	tt, d tts aff e
	Resident #9 and too neglected to call or s of 1 resident reviewe Resident #9 was fou wheelchair in cardiac in the facility on 06/1 Immediate jeopardy	k it off the wall. Nurse #2 seek medical assistance for 1 ed for neglect (Resident #9). and slumped over in his c arrest. Resident #9 expired		times per week for 4 we signs of abuse. Adminis will conduct interviews va BIMS 12 and higher o times per week for 4 we residents 3 times per we	eks to look for strator or designer with residents with n 5 residents 5 eks, then 5 eek, then 5 eek to ask	h

Facility ID: 923249

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3		OATE SURVEY COMPLETED
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 179 COMBS STREET SPARTA, NC 28675	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	was removed on 06/implemented an accimmediate jeopardy remain out of compliseverity E (no actual minimal harm that is ensuring monitoring completion of staff ed. The findings included 1. Resident #11 was 11/21/22 with diagnovascular accident, didementia. A review of Resident 12/07/22 revealed the assistance with her a related to left hemipa. The goal indicated henticipated and metaparticipate in the actiprovide the amount of complete the task and light. Further review dated 12/07/22 revealed	ant care. Immediate jeopardy 23/23 when the facility eptable credible allegation of removal. The facility will ance at a lower scope and harm with more than not immediate jeopardy to systems are in place and the ducation. d: admitted to the facility on uses that included cerebral abetes mellitus and abetes mellitus and at #11's care plan initiated and activities of daily living (ADL) aresis and mood symptoms. For eneeds would be through encouraging her to do it in a promptly answering call of the Resident #11 exhibited behaviors by making false aff, continuously ringing call of conversation, periods of sing combative with staff, go her arms causing abrasions will call staff names and hit care. The goal that the are giver support when	F 60	neglect will be investigated im 5. Administrator will bring the results to the Quality Assurant Committee meeting monthly from the consecutive months. The Quality Assurance Committee will evaluate effectiveness of the above plasmake additional interventions recommendations based on the ensure continued compliance. 6. Date of completion August	ne audit ce for three ality aluate the an and will and he audits to	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		DATE SURVEY COMPLETED
		345261	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	ı	07/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	starting and allowing feelings. A review of Resider dated 02/04/23 revisues documented. The quarterly Minimassessment dated Resident #11 was and had no behavior reference period. Review of the Initia abuse dated 02/16, was notified during Resident #11 had rand left arms. Nursithe accused individe the Administrator. A review of the Investigation of the Administrator. A review of the Investigation of the Administrator in statements indicated #9, NA #10 and NA Resident #11 while to hit, bite and scraattempting to changeshe did not hold the	are for care task before g the Resident to express her that #11's skin assessment ealed there were no skin l. The mum Data Set (MDS) The model of the control of the cont	F 60	<u>'</u>		
	indicated that she of together so that the Resident without be statements were co	lid hold the Resident's hands e staff could finish changing the eing injured. All the staff's ensistent indicating that being combative with staff and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345261	B. WING				C 12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 179 COMBS STREET SPARTA, NC 28675	DDE	<u> </u>	12/2025
(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 X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 600	physical injury of discileft and right forearm substantiated. The suffound that staff did he arms to keep her from them. During an observation Resident #11 on 06/2 Resident was alert at bed, well-groomed at Resident held the bewhich was resting net the call light and her explained that she valincident when two gir who they were, held bruises on her hands when it was or any dishe thought it was just There were no bruise Resident's arms or has	note. The incident resulted in colorations to the Resident's is. The incident was immary of the investigation old down the Resident's in hitting and scratching in and interview with 10/23 at 10:10 AM the individual to the indivi	F	600	<u>')</u>		
	9:40 PM the NA explanation she was ask Resident #11 because combative so they may go into the Resident's NA stated Resident # bottom and desperational she agreed to let #11 started to pull he picked up her bed resident which made a stopped and called Narroom and the Nurse for the stopped she was asked to pull her picked up her bed resident which made a stopped and called Narroom and the Nurse for the stopped she was asked to pull her picked up her bed resident which made a stopped and called Narroom and the Nurse for the stopped she was asked to pull her picked up her bed resident was asked to pull her picked up her bed resident was asked to pull her picked up her bed resident was asked to pull her picked up her bed resident was asked to pull her picked up her p	with NA #9 on 06/20/23 at a mained that during that night in seed to assist NA #11 with the ethe Resident can be ust have 2 staff members to be room to render care. The set 11 "was soiled from top to be ely needed to be changed" at them change her. When NA or covers down Resident #11 mote and hit NA #11 on her loud thud." She stated they urse #7 into the Resident's ried to talk her into letting but the Resident still refused					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	١ , ,	ATE SURVEY OMPLETED
		345261	B. WING _			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	'	· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 600	care. The NA stated that staff hit her, ever already had bruising verified by Nurse #7 An interview was co 06/20/23 at 7:52 PM #11 who was assign night of 02/15/23 to refused to be chang and soiled with urine that by the time Reschange her she requivith her soiled brief that when they were Resident #11 started attempting to bite the Resident #11 onto h #10 indicated that slarms between their bodies so they could from scratching. The did not touch the Re Resident was bruise present before they care. The NA stated #11 the way that she Nurse Educator whe combative residents On 06/22/23 at 8:15 NA #11 the NA explator Resident #11 on 0	not being able to provide , later the Resident reported en though the Resident #11 non her left hand that was . Inducted with NA #10 on I revealed the NA assisted NA ed to Resident 11 during the 02/16/23, when the Resident ed for hours and was soaked e and stool. NA #10 stated ident #11 allowed them to uired a full bed change along and gown. The NA explained halfway finished with the task d pinching, scratching, and em. When they rolled er side facing NA #10, NA he had to pin Resident #11's (Resident #11 and NA #10) If finish care and prevent her e NA was insistent that she sident's hands that if the d then the bruising was went into her room to provide that she positioned Resident e had been taught by the en the staff had to care for	F 6	,		
	refused. She stated could literally smell t	hift, and multiple times she by the early morning you he strong urine and bowel ne hallway and when she did				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 7/ 12/2023
	ROVIDER OR SUPPLIER	340201		STREET ADDRESS, CITY, STATE, ZIP CO 179 COMBS STREET SPARTA, NC 28675	T 75 VIDER'S PLAN OF CORRECTION	
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 600	brief change complesheets. NA #11 reports the Resident's room to pick at a sore on his bleeding but the Ressore. NA #11 explain the Resident's inconthrough the process scratch, pinch and a swinging the bed rerto explain when they NA #10 the NA had to down and lean over from scratching them but NA #10 never hedown. The NA stated bruising on Resident	e 18 e her the Resident required a te with her gown and bed rted that Nurse #7 came into and asked the Resident not her hand because she had it ident continued to pick at the ed NA #10 assisted her with tinence care and halfway the Resident began to tempted to bite them while hote at them. She continued turned the Resident towards to lay the Resident's arms her to prevent the Resident h and to finish changing her, ld the Resident's hands I she did not notice any #11's hands or arms she would have reported it.	F 60	00		
	06/20/23 at 8:40 PM worked with Resider evening shifts and w morning of 02/16/23 Resident #11 alread and hands before the Resident had pulled earlier in the shift an and had it bleeding wasked her several tirthe skin tear that she she continued to pict the Resident had brubut she did not report document the bruisir bruising. That night I be changed multiple	nducted with Nurse #7 on who explained that she at #11 often during the as on duty on 02/15/23 to the The Nurse reported that y had bruises to her arms at evening shift because the a band aid off her left arm d was picking at the skin tear with blood on her bed and I mes that night not to pick at e was making it worse, but at the skin tear. She stated aise's on her arms as well, the bruising, nor did she ag because she always had Resident #11 had refused to times but at one point she d so all three NAs went in				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	' '	ATE SURVEY DMPLETED	
		345261	B. WING			C 07/12/2023	
	ALLEGHANY CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 600 Continued From page 19 there to change her because they did not allow one aide to provide care for Resident #11 because of her behaviors. During an interview with Nurse #6 on 06/20/23 at 8:56 PM the Nurse confirmed she was on duty the night of 02/15/23 to 02/16/23 and assisted Nurse #7 in attending to Resident #11. Nurse #6 stated she did not remember or know about any bruising on Resident #11, but she knew that Nurse #7 had walked in on the Resident picking at a sore on her arm and had it bleeding. The Nurse reported that Resident #11 had refused care multiple times even after calling out for it several times that night. She stated she had instructed the NAs not to go into the Resident's room by themselves to provide care because of Resident #11's combative behaviors and false accusations toward the staff and she felt that was best for everyone's protection. Nurse #6 stated that she was not aware of any accusations made by Resident #11 against any of the NAs that worked that night until she came back on duty and learned that NA #10 was suspended because she crossed the Resident's arms in order to roll her over to provide care and NA #9 and Nurse #7 were in the room at the time. An interview was conducted with the Unit Manager (UM) on 06/20/23 at 1:50 PM who explained that she did not know any details about an incident with Resident #11 and NAs #9, #10 and #11 on the night of 02/15/23 to 02/16/23			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		07/12/2023	
PRÉFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 600	there to change her one aide to provide because of her beh During an interview 8:56 PM the Nurse the night of 02/15/2 Nurse #7 in attendir stated she did not rebruising on Resider Nurse #7 had walke at a sore on her arm Nurse reported that care multiple times several times that ninstructed the NAs room by themselves Resident #11's com accusations toward best for everyone's that she was not aw by Resident #11 ag worked that night un and learned that NAshe crossed the Reher over to provide were in the room at An interview was commanger (UM) on 0	because they did not allow care for Resident #11 aviors. with Nurse #6 on 06/20/23 at confirmed she was on duty 3 to 02/16/23 and assisted ing to Resident #11. Nurse #6 emember or know about any int #11, but she knew that ed in on the Resident picking in and had it bleeding. The Resident #11 had refused even after calling out for it in ight. She stated she had not to go into the Resident's is to provide care because of abative behaviors and false the staff and she felt that was protection. Nurse #6 stated vare of any accusations made ainst any of the NAs that intil she came back on duty A #10 was suspended because sident's arms in order to roll care and NA #9 and Nurse #7 the time.	F 60	,			
	an incident with Reand #11 on the night except that she was on 02/16/23 to com Resident #11 that shands, but she could the UM stated Res	sident #11 and NAs #9, #10					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 7/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		1111212023
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	2:25 PM the NA expl 02/16/23 she overhehow Resident #11 haremote and they took when she went to se overheard the convebruising on both han skin tear which had shad dried blood on it already been tended bruising was not there she dried her hair, an On 06/20/23 at 8:000 the Activity Assistant visited Resident #11 and noticed the bruis Resident told her that when they were charactivity Assistant corrusted the NA (don't hall what happened, #11 was trying to hit shift while they were to hold her hands do top of her hands to p being combative whith the only educate that occurred, and she to provide care for R	with NA #7 on 06/20/23 at ained that on the morning of ard some aides talking about at hit NA #9 with her bed at it from her. She stated be the Resident right after she resation, the Resident had does, near her elbow and a steri strips on her hand that that looked like it had to it. The NA stated the rethe Tuesday prior because and it wasn't there. PM during an interview with she explained that she on the morning of 02/16/23 sing and skin tears on the hands. She stated the they held her hands down aging her last night. The attinued to explain that she remember who it was) on the the NA told her that Resident and bite the NAs on the night changing her and they had wn, with their hands flat on revent the Resident from the they changed her. Inducted with the Nurse 3 at 9:00 PM who explained and the staff after the events are had educated the staff not esident #11 alone, always when providing her care	F6			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY DMPLETED	
		345261	B. WING			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		0771272023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	Nursing (DON) on Oreported he was the through most of Feberal explained that he result that she frequently abusive to her and froom to provide carwith at least 2 peopprovided. The Resident and bed remote as threatening to hit the An interview was considered that the sum of t	with the former Director of 16/22/23 at 2:55 PM the DON exacting DON from January pruary 2023. The DON exembered Resident #11 in execused the staff of being they were afraid to go into her experience for her, so I had them go in the le and to document the care dent liked to use her call light a "lasso" and swing at them, em.	F 60				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G		ATE SURVEY DMPLETED
		345261	B. WING _			C 07/12/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	'	01712/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	je 22	F 6	00		
	down and NA #11 w Resident's hands do	ho denied holding the wn.				
	The Administrator w jeopardy on 07/12/2	as notified of the immediate 3 at 4:49 PM.				
	The facility provide t	he following IJ removal plan:				
		ents who have suffered, or serious adverse outcome as impliance.				
	Administrator was no new discolorations to Administrator and In the room to interview information on the narms. Resident #11 woman held her down discolorations. The up to the event, Resonot recall. The Administrator as describe the event, I happened during the attempted to change her hands together. was a large nurse ai Facility staff interview from the previous night that Resident #11 wattempted to change	on am on 2/16/2023 the obtified that Resident #11 had on her right and left arms. The fection Preventionist entered we Resident #11 to gather ew discolorations to her stated that a large black who last night causing the Administrator asked what led ident #11 stated she could inistrator asked when the ident #11 stated last night. Sked Resident #11 to Resident #11 stated "it et time the nursing aides et me" and the nurse aide put Resident #11 then stated it de who held her down. Wed the staff working the hall ght shift, interviews indicate as combative with staff who held his part of the policy and bedding the Administrator solloged.				
	written statements fr involved in the allega- during the care and	e Administrator collected om the NAs that were ation. NA #11 was present denied holding the residents' denied holding the residents'				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		31112/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	ge 23 roviding care. NA #10 stated	F 60	0		
	the resident was cor	mbative while providing care sidents' hands together to				
	room and witnessed Resident #1 breast a clothing. Nurse Aide	ide #1 entered Resident #1 Resident #2 touching and vagina through her e #1 asked Resident #2 to ent #1 and he did				
	stop touching Resident #1 and he did immediately. Nurse Aide #1 went and reported to Nurse #1. Resident #1 reported that Resident #2 entered Resident #1's room again on 3/20/23 and tried to touch and kiss her. Resident #1 was sent to the Emergency Department on 3/21/23 for evaluation and returned to the facility. Resident					
	psych services. Resident #2 no long residents have the p resident-to-resident cognitive impairmen	er resides in the facility. All otential to be involved in abuse but residents with t, dependent transfer re more vulnerable to such				
	conducted interviews residents having a B ensure there were n On 6/21/23 the Director of Nursing a skin assessments or	al Worker and Administrator s with alert and oriented slMs of 12 or greater to o other reportable incidents. ctor of Nursing, Assistant and Unit Manager completed or residents that are not alert were no concerns identified.				
	process or system fa	ne entity will take to alter the ailure to prevent a serious or occurring or recurring, and be complete:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 179 COMBS STREET SPARTA, NC 28675		1111212025
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 600	on 6/21/23 the Director of Nursing edepartments on Abus verbal abuse, sexual mental abuse, negled exploitation, misappr property, resident to mistreatment. Staff vany changes in behavior, resident while reportisupervisor and additiinto place. The staff 12 and greater were Nursing, Assistant Di Regional Nurse Consone-to-one verbal coany type would not be the residents with a Ewas contacted with the Director of Nursing at that staff members, thave not received the to work until they have the event abuse is we should stay with the from the abuse. Further educated to remain vare alleging abuse of Director of Nursing whired staff, including Education was given	completed on 3/22/23 with fying abuse. Itor of Nursing and Assistant ducated current staff in all se. Education included abuse, physical abuse, ct, involuntary seclusion, opriation of resident resident abuse and were educated on identifying vior or patterns that may be to-resident abuse. Staff in educated that if they identify they should monitor the ng the concern to their onal monitoring will be put and residents with Bims of informed by the Director of irector of Nursing or the sultant on 6/22/23 in mmunication that abuse of e tolerated in this facility. For BIMs of 11 or less the RP ne same education. The nd Administrator will ensure or include agency staff, that e education will not be able we received this education. In itnessed the staff member resident providing protection	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345261	B. WING		C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	07/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 600	Effective 6/21/2023 responsible for ensimmediate jeopard non-compliance. Alleged Date of IJ IV Validation of the implan was conducte The interviews with were reviewed with The skin assessme residents were reviewed. The o3/21/23 was revieconcerns noted. The 03/21/23 was reviecompleted on 06/2 sheets to verify conthe education. The different types of all how/when to report and the importance Administrator of an abuse. The abuse included in the new for any newly hired across all departme were able to verbal procedure. They we ducation points of immediately protect reporting the suspet the facility Administration of 06/23/23 with the control of t	en in verbal format with written le types of abuse provided. 8, the Administrator will be suring implementation of this y removal for this alleged Removal: 6/23/2023 Imediate jeopardy removal do in the facility on 06/28/23. In alert and oriented residents in no additional concerns noted. Bent of non-alert and oriented ewed with no additional the initial education from wed along with the education 1/23 along with staff signature impletion and understanding of education included the buse, how to stop the abuse, to of immediately notifying the sy suspected or witnessed education was verified to be of hire orientation information staff. Interviews with staff ents in the facility revealed they hire orientation information staff. Interviews with staff ents in the facility revealed they have able to verbalize the stopping the abuse and ting the residents and exted or witnessed abuse to trator. The facility's IJ removal as validated.	F 60		
	 Resident #1 w 01/18/23. 	as admitted to the facility on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	_	ge 26 icant change Minimum Data 3/13/23 revealed that Resident	F 60	00		
	#1 had clear speech needs known and w Resident #1 was mo	n and was able to make her vas able to understand others. oderately cognitively impaired I to extensive assistance with				
	04/01/21 with diagn	lmitted to the facility on oses that included anxiety, sorder, vascular dementia,				
	08/06/21 read Resides sexually inappropriate members. The goal verbalize an increase demonstration of complete demonstration of complete demonstration for potential properties and report an evaluate need for best sexually inappropriate Resident #2 in a call reassure as necessis combative or resisting members.	an for Resident #2 initiated on dent #2 tends to exhibit ate behavior towards staff read, Resident #2 will sed understanding and ontrol of sexually inappropriate eventions included: monitor cential contribution to sexually viors, monitor laboratory test bnormal results to physician, chavioral health consult, when ate behaviors occur, approach lm, unhurried manner, ary, if Resident #2 becomes we postpone care/activity and o regain composure, provide				
	privacy as needed, feelings, divert Resi objects or activities, resident, and removenvironment. Review of the quart assessment dated (allow time for expression of dent #2 by giving alternate listen and try to calm				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345261	B. WING		07/12/2023
	NY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	1 01112/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 600	or wandering durin period. Resident # assistance with ac wheelchair for mot Review of a facility read, Resident #1 came into her room and kissing her ha her breast on top colothing, then tried Resident #1 stated stop, and he did. Fexact date and tim Resident #1 was a were noted. An inv Resident #2 was p supervision. Residemt #2 was p supervision. Residemt was comple (DON). Resident #2 was did the resident #2 was comple (DON).	b behaviors, rejection of care, g the assessment reference 2 required limited to extensive tivities of daily living and used a bility. Incident report dated 03/21/23 reported that Resident #2 and started holding her hand and, then proceeded to touch of her clothing and under her to touch her vaginal area. It that she asked Resident #2 to desident #1 was not sure of the ethe incident occurred. It is sessed for injuries, and none destigation was initiated. I laced on one-on-one ent #1 was sent to the ement (ED) for evaluation. The ted by the Director of Nursing ischarged home from the	F 60	,	
	revealed that Nurs Resident #1 and N Resident #1 reside An observation and with Resident #1 o Resident #1 was re groomed. She stat incident with Resid know the date or ti room but could not	ity's schedule for 03/19/23 e Aide (NA) #1 was caring for urse #1 was on the unit where			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		0771272020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	touch my vagina but She explained that I clothes, but she did stated she tried to be because she did no happened to her. Respouse had recently not want another mathat Resident #2 had inappropriate gesture before but again she incident anymore. Nurse Aide (NA) #1 06/20/23 at 2:33 PM caring for Resident that evening Reside her room and Reside smoking entered Resident #1's room, wheelchair. NA #1 sesident #1's room, wheelchair's facing stated to her, "please from my twat", NA #1 hand was on top of vaginal area. NA #1 Resident #2 to stop did. NA #1 stated the Resident #1 and Resident #1 and Resident #1 of which was returning to Resident #2 in the freturning to his room stated that both Resident and orient going on, and Resident going on, and going o	me on my breast and tried to t I pushed his hand away." he touched her on top of her not like to talk about it and lock it from her memory t like to think about what had esident #1 explained her passed away and she did an touching her. She added	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER	1.020		STREET ADDRESS, CITY, STATE, ZIP COD 179 COMBS STREET SPARTA, NC 28675		07/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	tearful but appeared stated that at the end reported what had on followed up with Nurse documented what hat that Nurse #1 stated anything regarding the was consensual. NA think anything about Resident #2 in the roto report to Nurse #1 removed his hand from She added that she acare of what she need incident. Attempts to speak to 06/20/23 at 11:12 AMA A statement provided at 5:00 AM read on Simedication pass, star witnessing Resident and had his hand in Fresidents were sitting. This Nurse asked Reand she replied, "so the what I want." Resider language and reported incident was consensinvolved. NA #7 was interviewed 3:20 PM who confirm Resident #1 on 03/20 stated that during reported the resident was consensinvolved.	sident #1 was not sad or like her usual self. NA #1 of her shift she had courred to NA #7 and se #1 about if she had doccurred. NA #1 stated she had not documented the incident because she felt it #1 stated that she did not leaving Resident #1 and som together while she went because "he instantly the her when I asked him to." assumed Nurse #1 had taken ded to regarding the Nurse #1 were made on I and were unsuccessful. I by Nurse #1 dated 03/22/23 standay night 03/19/23 during ff reported to this writer of #2 in Resident #1's room Resident #1's brief while both in wheelchairs in the room. I sident #1 about the incident, this is my p***y, and I can do not #1 used other foul ed to this writer that the sual between the two parties	F6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			5 14/110				
		345261	B. WING _			07/	12/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	ÞΕ		
				179 COMBS STREET			
ALLEGHA	ANY CENTER			SPARTA, NC 28675			
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 600	Continued From page		F 6	000			
	Resident #1 on the or vaginal area and touch had reported the incide stated that Resident #2 to her about the incide that shift and was her that Resident #2 never toward other resident he did at times grab so the did at t	ed on 06/20/23 at 2:07 PM he was caring for Resident stated that Resident #1 had h and requested to get out of she and NA #6 were going to th getting up. During the that Resident #1 had tears her that Resident #2 had his t #1's pants and had NA #5 stated she left the yed with Resident #1 and t4 what Resident #1 had certain that Resident #1 was her eyes" when she told her and it was very clear that vant Resident #2 touching t after they reported to ed to the DON and					
	investigation. She add Resident #2 touch an inappropriately, but he would grab staff inapp NA #5 stated that Residuilding for a bit after one-to-one supervision	ey immediately began an ded that she had not seen other resident e did have a foul mouth and propriately from time to time. sident #2 stayed in the this incident, but he was on on until he discharged home.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 179 COMBS STREET SPARTA, NC 28675	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 600	#1 on 03/21/23 during that Resident #1 had and she and NA #5 we transfer. During the to that Resident #2 had he should not be touch was very clear she did touching her at all. In stated that Resident her pants and her broken had gotten Resident Nurse #1. NA #6 state told her and NA #5 we immediately reported DON and Administration investigation. NA #6 Resident #1 being the very clear she did no her. NA #6 stated that building for a few were supervision until her of the control of t	the was caring for Resident g the day shift. She stated requested to get out of bed were assisting with the ransfer Resident #1 stated touched her in places that ching her and Resident #1 id not want Resident #2 IA #6 stated that Resident #1 #2 had touched her inside east area, and that NA #1 #1 to stop and reported it to ed that when Resident #1 what had happened, they I it to Nurse #4 who told the tor and they began an stated she did not recall arful or sad, but she was to want Resident #2 touching at Resident #2 stayed in the eeks and was on one-to-one	F 60	,		
	not joking with them Resident #1 reported his hands down her pand NA #5 and #6 im reported to Nurse #4	like she normally did. I that Resident #2 had stuck pants and touched her breast				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345261	B. WING		,	C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 179 COMBS STREET SPARTA, NC 28675		1111212023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	which she was and r Nurse #4 explained to facility since January with Resident #2 or had worked with Resi inappropriate behaving. Review of an ED not part, patient presents after being referred for potential sexual asses patient came into the the breast and vaging sexual act performed how many days ago between 3 and 5. Vat performed because we days ago this has be states there was not penetration. The ED patient was brought evaluation of sexual somewhere between of a man touching he states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states that he never nor did he have pened the states	sent to the ED for evaluation eturned with no new orders. hat she had worked at the 2023 but was not familiar his history but the time she sident #2 this type of or was not his normal. e dated 03/21/23 read in so to the emergency room rom the nursing home of hault. The patient states that a room and touched her on a. There was never any states in the impossible to know this was but probably ginal exam was not we are unsure how many en and by history the patient couching her with his penis or disposition read, discharge, to the emergency room for assault. This occurred a to 5 days ago. It consisted or breast and vagina. Patient touched her with his penis, etration into her vagina. his late in to perform a here was no penetration ent. Even if there had been re too many days that have	F 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345261	B. WING		C 07/12/2023
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 79 COMBS STREET PARTA, NC 28675	1 077122323
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 600	Resident #2 had coher on her breast and did not want him to stated that following interviewed the other on the unit to see if occurred and none continued to check while after the even. The Psychiatric Nurinterviewed on 06/2 had seen and evaluates in the facility. Had seen and oriented a knew how he was fistated he became at Resident #1 and Refurther stated that he behaviors including to staff, but to his knincident that had on while Resident #2 who stated that had now while Resident #2 who stated that had on while Resident #2 had to stated that she had assessment of Resand then had Nurse evaluation. The DO stated Resident #2 top of her clothes a	the recounted the events that me into her room and touched and vaginal area and that she uching her at all. The SW of the interview she had er alert and oriented residents any other incidents had were reported, and she on Resident #1 daily for a tt. The see Practitioner was 11/23 and confirmed that he hated Resident #2 while he hated Resident #2 while he had along with depression but was not knew what was going on, seeling. The Nurse Practitioner havare of the incident between resident #2 and saw Resident micident had occurred. He resident #2 had a history of being sexually inappropriate moviedge this was the only courred with another resident	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER NY CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		07/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	03/21/23 at which initiated. All staff the initiated. All staff the interviewed as well was placed on one discharged home at The DON indicated and oriented and a She stated that she statement indicating consensual, but she Resident #1 and Noterminated from the NA #1 should not he Resident #2 alone should have immediate incident between F. 1. The Administrator of 4:59 PM who state incident between F. 03/21/23 and he in residents were septiments.	age 34 as not reported to her until cime the investigation was nat were involved were as the residents, Resident #2 -to-one supervision until he a few weeks after the incident. It that Resident #2 was alert ware of what he was doing. It had reviewed Nurse #1's g that the incident was e never got that response from urse #1 was ultimately e facility. The DON stated that have left Resident #1 and together in the room, she diately stopped the abuse and #2 from the room then alerted was interviewed on 06/20/23 at d that he was notified of the Resident #1 and Resident #2 on mediately made sure the harated and began his stated Resident #2 was placed	F 60			
	interviewing the stathrough 03/21/23 to and what was reported that he house of the first of the house of the	pervision and they began aff that worked from 03/19/23 of find out what had occurred orted. The Administrator had interviewed Resident #1 on eported that Resident #2 came do touched her on breast and he did not like that. Then hed that on 03/20/23 Resident her own and tried to touch do she reported feeling "unsafe" Administrator stated he notified hent and Resident #1 was sent attion and returned. During the				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		I ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING_			C
	ROVIDER OR SUPPLIER	040201		STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	<u> </u>	07/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	Resident #1 was ve consensual, and she touching her. The A he became aware obegan his investigat immediately protect abused. The Administrator wijeopardy on 06/21/2 The facility provided Identify those recipicare likely to suffer, a a result of the noncomplete Administrator was new discolorations to Administrator and In the room to interview information on the narms. Resident #11 woman held her down discolorations. The up to the event, Resident #11 woman held her down discolorations. The up to the event, Resident #11 woman held her down discolorations. The up to the event, Resident #11 woman held her down discolorations. The up to the event, Resident #11 woman held her down discolorations. The up to the event, Resident #11 woman held her down discolorations. The up to the event, happened during the attempted to change her hands together. was a large nurse a Facility staff intervie from the previous ni	ministrator stated that ry clear this was not e did not want Resident #2 dministrator stated that once f the incident, he immediately cion and educated the staff on ing the resident who had been ras notified of the immediate 3 at 8:41 AM. I the following IJ removal plan: ents who have suffered, or a serious adverse outcome as	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		I DENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345261	B. WING		C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	1 07/12/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 600	that were soiled. The written statements froi involved in the allegal during the care and dhands down. NA #9 hands down while prothe resident was comand she held the resident was comand she held the resident was deroom and witnessed Resident #1 breast at clothing. Nurse Aide stop touching Reside immediately. Nurse #1. Resident #1 tried to touch and kiss to the Emergency De evaluation and return #1 was seen and will psych services. Resident #2 no longeresidents have the poresident-to-resident acognitive impairment, statuses and such are situations. On 6/21/23 the Social conducted interviews residents having a Br Status (BIMS) of 12 cowere no other reports	her clothing and bedding Administrator collected om the NAs that were tion. NA #11 was present enied holding the residents' denied holding the residents' oviding care. NA #10 stated bative while providing care dents' hands together to the #1 entered Resident #1 Resident #2 touching and vagina through her #1 asked Resident #2 to ant #1 and he did Aide #1 went and reported to #1 reported that Resident #2 #2 froom again on 3/20/23 and #3 her. Resident #1 was sent partment on 3/21/23 for ed to the facility. Resident continue to be seen by The resides in the facility. All otential to be involved in buse but residents with dependent transfer the more vulnerable to such I Worker and Administrator with alert and oriented in greater to ensure there able incidents. On 6/21/23 g, Assistant Director of	F 60		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON: AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE COMP	SURVEY LETED			
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		345261	B. WING			07/	12/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 600	Continued From page	e 37	F	600			
	assessments on resid	dents that are not alert and					
	oriented. There were	no concerns identified.					
	Specify the action the	e entity will take to alter the					
		ilure to prevent a serious					
		n occurring or recurring, and					
	when the action will b	pe complete:					
	Initial education was	completed on 3/22/23 with					
		ying abuse. On 6/21/23 the					
		nd Assistant Director of					
	Nursing educated current staff in all departments						
	_	included verbal abuse,					
		al abuse, mental abuse,					
		eclusion, exploitation,					
	misappropriation of re	esident property, resident to					
	resident abuse and m	nistreatment. Staff were					
	educated on identifyi	ng any changes in behavior					
	or patterns that may l						
	resident-to-resident a						
		ucated that if they identify					
	_	they should monitor the					
		ng the concern to their					
	•	onal monitoring will be put					
	•	and residents with Bims of					
	_	informed by the Director of					
	_	rector of Nursing or the					
	Regional Nurse Cons	mmunication that abuse of					
		e tolerated in this facility. For					
	, ,,,	BIMs of 11 or less the RP					
		ne same education. The					
		nd Administrator will ensure					
	_	o include agency staff, that					
		e education will not be able					
		re received this education. In					
		tnessed the staff member					
	should stay with the r	resident providing protection					
	from the abuse. Furt						

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345261	B. WING		C 07/42/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	07/12/2023		
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F 600	are alleging abuse on Director of Nursing with hired staff, including Education was giver format and the staff to confirm understant Education was giver key points to include Effective 6/21/2023, responsible for ensuint immediate jeopardy non-compliance. Alleged Date of IJ Roward Validation of the immediate jeopardy non-compliance. Alleged Date of IJ Roward Validation of the immediate jeopardy non-compliance. Alleged Date of IJ Roward Validation of the immediate jeopardy non-compliance. Alleged Date of IJ Roward Validation of the immediate jeopardy non-compliance. Alleged Date of IJ Roward Validation of the immediate jeopardy non-compliance. Alleged Date of IJ Roward Validation of the immediate jeopardy with a were reviewed with interviews with a were reviewed with interviews with a were reviewed on 06/21/3 sheets to verify completed on 06/21/3 sheet	with the resident when they in someone present. The will provide education to newly agency during orientation. In a verbal and/or written were asked to give feedback ding of the education. In verbal format with written types of abuse provided. The Administrator will be ring implementation of this removal for this alleged	F 60				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345261	B. WING _			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 179 COMBS STREET SPARTA, NC 28675		1 07/12/2023	
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F 600	the facility Administrated atte of 06/23/23 was 3. Resident #9 was ir on 08/24/22 and read 04/05/23 with diagnotobstructive pulmonar failure, coronary arterfibrillation. Resident #9's care placed the Resident complications related pulmonary disease a The goal was that Resigns or symptoms of would be attained by interventions: obtaining reporting to the physician as indicate (difficult or labored by muscles which indicated observe respiratory schanges as well, medicated with the resident's care refused medications care related to activite interventions included the importance of takes.	ing the residents and sed or witnessed abuse to other. The facility's IJ removal validated. Initially admitted to the facility dimitted to the facility on ses that included chronic by disease, congestive heart ry disease, and atrial Initiated 08/25/22 at was at risk for respiratory of the congestive heart failure. The sident #9 would have no for respiratory distress that sutilizing the following for glabs as ordered and cian as indicated, during sestion of breathing) the color and report to do, observe for dyspnea reathing) use of accessory status and changes in mental dicate as ordered and tes, monitor and record lung report oxygen saturation is ordered via nasal cannula. The plan also indicated he and treatments and refused dies of daily living. The died educating the Resident on ling his medications and ting to the physician when	F 6				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 600	was cognitively intachis activities of daily indicated the Reside bladder and bowel. during the assessment of Resident revealed the following orders: *11/25/25 Carvedilo milligrams (mg) table *04/25/23 Diltiazem capsule by mouth etable to by mouth one *08/24/22 Furosemi mouth every 24 hours activities of daily interest of the residual of the resid	Jum Data Set (MDS) 24/10/23 revealed Resident #9 ct and was independent with r living. The MDS also ent was always continent of There was no refusal of care ent reference period. It #9's medical record ing medication and treatment I (antihypertensive) 25 et by mouth twice a day. (for heart rate control) 90 mg very 12 hours. (antihypertensive) 40 mg time a day. de (diuretic) 40 mg tablet by irs as needed for congestive rith Potassium Chloride 20	F6	00			
	one time a day. *04/06/23 Ventolin I- Solution 108 (90 Ba orally four times a d with spacer. *05/26/23 Apply Uni dressings/wraps use bilateral legs once a and Friday. A review of Residen 06/13/23 at 5:07 AM up and down from th vice versa most of th complaining of pain	uretic) 50 mg tablet by mouth HFA Inhalation Aerosol se) MCG/ACT 2 puffs inhale ay for wheezing/dyspnea, give na boots (medicated ed to reduce swelling) to a day on Monday, Wednesday, It #9's progress noted dated If revealed, the Resident was ne bed to the wheelchair and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
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F 600	sanguineous (bloody He previously cut of allow staff to replace meds and care. Unawith any care current medication and or trextremities. The not A review of Residen 06/13/23 at 5:59 AM Inhalation Aerosol S (mcg) (90 Base) 2 p day for Wheezing/Dinhaler. Refused mewritten by Nurse #2. A review of Residen Administration Record Resident #9 refused 06/13/23 at 6:00 AM A review of Resident #9 refused 06/13/23 at 6:40 AM staff, upon arrival Record in wheelchair, restimuli, blue in color on floor and initiated Resuscitation (CPR until 911 arrived. Pronotified. The note with the confirmation of 06/20/23 at 9:10 Nurse #2 she confirmation Resident #9 about 3 night of 06/12/23 un The Nurse reported oriented and was not staff.	mities draining serous y) fluid in moderate amounts. f Unna boots and refused to e them. Non-compliant with all able to allow staff to assist titly. Will continue to offer pain eatment to bilateral lower e was written by Nurse #2. It #9's progress note dated revealed, Ventolin HFA olution 108 micrograms uffs inhale orally four times a yspnea give with spacer dication. The note was It #9's Medication rd for 06/2023 indicated his Ventolin Inhaler on l. It #9's progress note dated revealed, called to room via esident noted to be slumped non-responsive to verbal with no respirations. Placed Cardiopulmonary 1. 911 called. CPR continued prounced at 7:00 AM. MD as written by Nurse #2. PM during an interview with med that she took care of regists a week and on the till the morning of 06/13/23. the Resident was alert and	F 6			

	` IDENTIFICATION NUMBER: `		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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R SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 011	ILILOLO	
ER							
			SPA	RTA, NC 28675		1	
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icated dressi Resident's lessores and higher on the night on the night on the night on any other resident that was up and of at one time to the would of the the would of the the would of the Resident of the the would of the the found the on the wall of the call 911. See Resident and because he exported if she he hospital see the hospital see the hospital seed that she lated to call 910. All the continuing the waste of the wall of the continuing she waste of the wall of the continuing she waste of the continuing she waste of the continuing she waste of the continuing the continuing the continuing the continuing the continuing the waste of the continuing the waste of the continuing the con	ing to his legs. She explained ags were edematous and had be would cut the medicated enurses applied them. The Resident #9 acted no of 06/12/23 to 06/13/23 than hight that she had taken care envery Resident was restless in down from his bed to the entert anything unusual for him attempt himself on the floor. Hent complained of pain in his take pain medication for the floor anything unusual for him attempt himself on the floor. Hent complained of pain in his take pain medication for the floor and the Resident using the limit in the hallway saying he whe stated she took the phone and removed the phone from called 911 all the time. The enthought he warranted being the would have called 911 all the time. The enthought he warranted being the would have called 911 all the time. The enthought he was sitting the hallway, and she gave aller which was due at 6:00 and to explain that during the properties of the into Resident #9's room an sitting in his wheelchair at thate's bed. He was slumped sive. The Nurse continued to the Nurse Educator initiated	F	500				
	ed From page licated dressis Resident's lessores and higs off after the explained that it on the night in any other rishe stated the was up and of dat one time at that was not the would off the Resident and because he exported if she hospital is She reported if she hospital is she land to come down the she was and nonresponsithat she and the Nurse is sions first. N	IDENTIFICATION NUMBER: 345261 R SUPPLIER	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) TAG Bed From page 42 Iciticated dressing to his legs. She explained Resident's legs were edematous and had sores and he would cut the medicated gs off after the nurses applied them. The xplained that Resident #9 acted no con the night of 06/12/23 to 06/13/23 than n any other night that she had taken care She stated the Resident was restless in was up and down from his bed to the d at one time they found him lying in the it that was not anything unusual for him e he would often put himself on the floor. ted the Resident complained of pain in his refused to take pain medication for the urse #2 continued to explain that around I she found the Resident using the ne on the wall in the hallway saying he to call 911. She stated she took the phone e Resident and removed the phone from because he called 911 all the time. The exported if she thought he warranted being the hospital she would have called 911 She reported she attempted to obtain the tit's vital signs, but he refused. The Nurse and that she last spoke with Resident #9 in 6:00 AM to 6:20 AM when he was sitting ineelchair in the hallway, and she gave Ventolin inhaler which was due at 6:00 rse #2 continued to explain that during inge she was giving report to the ing nurse when nurse aides yelled for the o come down to Resident #9's room iney found him sitting in his wheelchair at of his roommate's bed. He was slumped d nonresponsive. The Nurse continued to that she and the Nurse Educator initiated the the Nurse Educator starting the chest essions first. Nurse #2 stated someone	A BUILDING 345261 B. WING STRE SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) FROM FROM BOTH OF THE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) FROM BOTH OF TAG BY TAG FROM BOTH OF TAG STRE SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) FROM BOTH OF TAG BY TAG FROM BOTH OF TAG STRE STRE STRE STRE STRE 179 0 SPAI SCHOOL STREET TAG FROM FROM	A BUILDING 345261 R SUPPLIER R SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES SACH DEFICIENCY MUST BE PRECEDED BY FULL EQUILATORY OR LSC IDENTIFYING INFORMATION) BY FROM PROPROP EQUILATORY OR LSC IDENTIFYING INFORMATION) BY FROM PROPH EQUILATORY OR LSC IDENTIFYING INFORMATION) FREFIX TAG FROM DEFICIENCY TAG FROM DEFICIENCY FROM DEFICIE	A BUILDING 345261 B. WING TRESUPPLIER TRE SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION) EGYPTION TO BE STATE AND CORRECTION ACH FOR THE STATE AND CORRECTION FROM TAG FROM FROM	

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F 600	Nurse Educator had Resident #9 not res Nurse again insiste #9's condition had of warranted being se have called 911 her A review of Resider 06/13/23 at 7:18 AM 6:42 AM, Resident respirations when a appearance, warm on call physician se (DON), and Reside note was written by An interview was concept to the was standing and Nurse Aides (NA) # nurse Aides (NA) # nurses to go down because they need when she and Nurse room, he was slumy sitting at the foot of Nurse reported she transferred the Resinitiated CPR by proafter it was determifull code, while Nurse policy. Resident #9 expired An interview was con 06/21/23 at 4:25 PM worked with Resident #9 w	d already stopped CPR due to sponding to the CPR. The d that if she thought Resident changed in a way that nt to the hospital she would	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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			179 COMBS STREET			
ALLEGHANY CENTER			SPARTA, NC 28675			
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F 600 Continued From p	age 44	F 6	500			
and Sunday night 06/13/23. The NA not his usual self to was restless, he we back to his bed like continued to explay found Resident #9 get Nurse #2 and Resident out of the where he always an ever known of the floor before. To asked the Resident denied be in the floor where for him. After som agreed to get into the and NA #3 left rounds. Then late this call light on an ambulance for him the ambulance. The never asked him to night and he went Resident and whe room the NA left to the NA stated that transpired betwee after he left the rood did not call an am the left off shift. The after he got home the facility called a had asked him to the person that he Nurse #2 that the	prior to the morning of Monday explained that Resident #9 was throughout the shift in that he was going from his chair then e he was restless. He in that earlier in the night he lying on the floor and went to NA #3 to help him get the e floor and back into his chair stayed. The NA reported he had e Resident preferring to lie in he NA explained that the Nurse at if he was in pain and the reing in pain and wanted to stay he said was more comfortable e encouragement the Resident his wheelchair. The NA stated the room to continue thier in the night Resident #9 turned d wanted him to call an an but did not say why he wanted he NA stated Resident #9 had to call an ambulance before that and got Nurse #2 for the in the Nurse went to Resident's he room to continue his rounds. It he did not know what the Resident #9 and Nurse #2 for, but the NA knew the Nurse bulance for Resident #9 before the NA continued to explain that that morning someone from and asked him if Resident #9 call an ambulance and he told and did, and the NA reported to Resident wanted an ambulance say why. The NA stated he had					

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F 600	4:59 PM the NA reportwo NAs that took caroutine basis but the morning of 06/13/23 aide and she helped explained that earlied him lying on the floor. Nurse #2 to help get floor. The Resident sthe floor, but they pu NA #3 left the room to continued to explain noticed Resident #9 phone on the wall in asked him what he wher that he was having wanted to go to the Resident #9 seemed and was pale, so she #2 who was at the nurse ident #9 was tryinallway phone and hot trouble breathing and the Nurse asked her phone from Resident #9 911 from the hall phot the Resident and tologo to the hospital but the Resident and tologo the Re	with NA #3 on 06/21/23 at orted that she was one of the re of Resident #9 on a night of 06/12/23 to the NA #4 was the Resident's with his care. NA #3 in the night NA #4 found and came and got her and the Resident up out of the tated he wanted to stay in thim back into his chair and to continue her rounds. NA #3 that around 4:30 AM she trying to call 911 using the the hallway. When the NA was doing the Resident tolding trouble breathing and hospital. The NA stated to be struggling to breathe e immediately went to Nurse urses' desk and told her that and to call 911 using the e stated he was having di was pale. The NA stated why she didn't just take the the first and the NA told the dn't look right and wanted to be NA reported Nurse #2 who was still trying to call one and took the phone from d him that he was asking to	F 60				
	to do for him then prophone from the wall. in his wheelchair still	oceeded to remove the Resident #9 sat back down looking pale and struggling ed Nurse #2 walked back to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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F 600	hall until she started AM to 6:00 AM. The Resident #9 was not because he would be do like go back and and he was normal was incontinent and stated she was cert behavior to Nurse # discussed how Resident #9 during The Nurse explained and oriented and pedaily living. The Nurse explained and legs we leathery, and he ago because he was prowas the only time he hospital. She did not calling 911. An interview was conceived the Resident #9's full till explained the Resident #9's full till explained the Resident was only to the side of the time and sometime of sethe time and sometime of sethe time and sometime of the time of the t	d did not come back to the dher med pass around 5:45 e NA stated she knew of this usual self that night normally do what he wanted to forth from his room to smoke y continent but that night he dhad to be changed. The NA ain she reported his change in the dident #9 was acting different with Nurse #3 on 06/21/23 at the reported she took care of day shift several days a week, do that the Resident was alert erformed his own activities of the continued to explain that do his medications and the ots that were used to control ower extremities. She stated 023, the swelling in his trunk, as so bad that his skin looked the red to go to the hospital etty much miserable and that the had asked to be sent to the out recall Resident #9 ever the onducted with NA #1 who was the NA on third shift. The NA dent was alert and oriented wants and needs. He was his urinal and would go to the other needed. Resident #9 had arely laid in his bed because	F 600			

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F 600 Continued From page 47 he said he couldn't breathe when he got into his bed. She stated he was a smoker and smoked throughout the night. The NA continued to explain that she had never known of Resident #9 using the hall phone and he had never asked her to call 911 for him. The NA stated the Resident would complain of pain in his legs but would refuse pain medication when it was offered to him. During an interview with the Director of Nursing (DON) on 06/21/23 at 1:15 PM the DON explained that after the morning meeting on 06/13/23 NA #5 informed her that third shift NA #3 reported that Resident #9 had fallen during the shift and had tried to call 911 himself by using the phone in the hall but Nurse #2 took the phone from him and did not assess him for a change in condition. She continued to explain that they found the Resident slumped over in his wheelichair and CPR was initiated but the Resident expired. The DON stated that based on the information she was given and the fact that there was no incident report about Resident #9's fall she reported the situation to the Administrator and an investigation was started because they felt Nurse #2 should have assessed the Resident's change in condition and notified the Medical Director for further orders. The DON stated the facility determined Nurse #2 was neglectful. An interview conducted with the Adult Protective Services (APS) Social Worker (SW) on 06/20/23 at 9:50 AM revealed she was concerned about Resident #9 who resided at the facility and expired the morning of 06/13/23. The SW explained that she received a reportable death notification from the facility Administrator who reported a nurse was being investigated for	F 600	he said he couldn't bed. She stated he we throughout the night, that she had never ke the hall phone and he of the hall phone and he shift and had tried to phone in the hall but from him and did not condition. She conting the information she we were was no incident fall she reported the and an investigation. Nurse #2 should have change in condition and investigation. Director for further of facility determined New Yes and the resident #9 who resexpired the morning explained that she renotification from the	reathe when he got into his was a smoker and smoked. The NA continued to explain nown of Resident #9 using e had never asked her to call stated the Resident would his legs but would refuse pain was offered to him. With the Director of Nursing at 1:15 PM the DON he morning meeting on meed her that third shift NA #3 nt #9 had fallen during the call 911 himself by using the Nurse #2 took the phone assess him for a change in mued to explain that they slumped over in his awas initiated but the ne DON stated that based on was given and the fact that at report about Resident #9's situation to the Administrator was started because they felt we assessed the Resident's and notified the Medical reders. The DON stated the urse #2 was neglectful. Ited with the Adult Protective all Worker (SW) on 06/20/23 she was concerned about ided at the facility and of 06/13/23. The SW eceived a reportable death facility Administrator who	F	300				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345261	B. WING			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	<u>'</u>	01712/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	the Administrator he learned of the situat morning of 06/13/23 investigation of the situation requested to go to the call 911 himself us from him and from the 1911 himself. The Nuthe Resident and cannot be call 910 himself. The Nuthe Resident and cannot be call 910 himself. The Nuthe Resident and cannot be call 910 himself. The Nuthe Resident and cannot be call 910 himself. The Nuthe Resident and cannot be call 910 himself. The Nuthe Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nuther Resident and cannot be call 910 himself. The Nut	5.5 AM during an interview with a reported that when he ion with Resident #9 on the he immediately started an situation and found that the laining of pain and had even he emergency room and tried ntil Nurse #2 took the phone he wall so that he couldn't call with the expectation of the expectation	F 6	,			
	had expired because of his history of refusing his medications and treatments that were necessary to prevent swelling and fluid overload which were related to his significant heart failure. The MD explained that he had recently counseled the Resident on the importance of taking his medications especially his medication (diltiazem) of which the Resident thought was poison. While reviewing Resident #9's death certificate the MD explained that the Resident went into biventricular dysrhythmia (arrhythmias that cause the heart to beat too fast, which prevents oxygen rich blood from circulating to the brain and body and may result in cardiac arrest) heart failure related to his coronary heart disease. He continued to explain that Resident #9's heart was beating so fast that						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345261	B. WING _			C 07/12/2023	
	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE 179 COMBS STREET SPARTA, NC 28675	E, ZIP CODE	VIII 2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ID TO THE APPROPRIA ICIENCY)		
F 600	a slight chance of su should have been sedepartment for further. The Administrator was Jeopardy at F 600 Nr. PM. The facility provided Immediate Jeopardy Identify those resider likely to suffer, a seri result of the noncommon on 6/13/23 at approximate approximate and the started their round be slumped over in we called for help. The Nresponded. Upon asseducator determined and did not have a put the floor by the Nurse practice resident was a full counter facility.	emergency room there was rivival but nevertheless, he into the emergency er evaluation. as notified of Immediate eglect on 06/22/23 at 2:30 a Credible Allegation of removal on 06/23/23. at who have suffered, or ous adverse outcome as a	F	600			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		0771272020
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	on 6/21/23 of her termoterial to be affect on 6/22/23 the Director of Nursing BIMs of 12 or greate experienced any characterial to be affect on the Director of Nursing for any characterial for resident, breath, new onset prissues identified with Specify the action the process or system fradverse outcome frowhen the action will on 6/22/2023 the Dicensed nurses on condition or assessition them on a resider condition. The nurse assessment of the rephysician, nurse proprovide them the infor the treatment of charge nurse is not	e contract agency was notified rmination. esiding in the facility have the ted by the deficient practice. ctor of Nursing or Assistant interviewed residents with a ger to identify if they had ange in condition. Residents eless had an assessment by ing or Assistant Director of anges not at baseline, not lethargic, shortness of pain, etc. There were no he this audit. The entity will take to alter the failure to prevent a serious form occurring or recurring, and the complete: irector of Nursing educated identifying changes in the failure to prevent and the complete of the with an acute change of	F 60	,		
	Director of Nursing. Nursing or Administ including clinical and the definition of neg of the facility, its em	On 6/22/23 Director of rator educated current staff d all ancillary departments on lect: "Neglect" means failure ployees, or service providers d services to a resident that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 179 COMBS STREET SPARTA, NC 28675		7/12/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	mental anguish, or eincluded that residen 911 at their will. On 6 Nursing and Assistar provided nurse aides a change of condition presents different that restless, or short of be provided both verball the staff members we understanding of whom. Staff members we Administrator or the langlect would not be that residents needs Any staff member, in unable to work until the completed. The Director ensuring education working. The Director education to new hire Effective 6/22/2023/2 ultimately responsible.	id physical harm, pain, motional distress. Education ts should be allowed to call id/23/23 the Director of int Director of Nursing education on how to identify in noting when a resident in known baseline, lethargic, oreath. Education was and in written format and ere asked to repeat in they were being educated ere reminded by the Director of Nursing that tolerated in the facility and to be addressed and met. In cluding agency, will be the education has been extered in the seen compared to the compared to the compared to the education has been extered in the seen compared to the education has been extered in the seen compared to the education has been extered in the seen compared to the education will be easily the education.	F 6				
	the removal of Imme was validated by the the facility had interv score of 12 or higher change in condition to The facility also assessore of 11 or below	ity's Credible Allegation for diate Jeopardy on 06/23/23 facility providing proof that iewed residents with a BIMs to identify if they had a hat had not been assessed. It is seed residents with a BIMs to identify if they had a ine conditions. There were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345261	B. WING	B. WING		1	C 12/2023	
	ROVIDER OR SUPPLIER			17	TREET ADDRESS, CITY, STATE, ZIP CODE 79 COMBS STREET PARTA, NC 28675	1 017	12/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	the facility was able to administration had pridentifying changes in which included comportanges and notifying orders when necessare and Director of Nursing about the definition of included the residents 911 at their will. The forwided educated to written information as demonstration on negondition. The facility neglect would not be the residents' needs for removal date of 06/20 Develop/Implement ACFR(s): 483.12(b)(1) §483.12(b) The facility implement written points appropriation of residents and exploited misappropriation of residents and exp	with the assessments. Arviews with the facility staff o verify that the rovided education on a conditions on the residents leting assessments on the g the providers for further ary. The facility Administrator ang educated all facility staff if neglect. The education is should be allowed to call facility administration in the nurse aides and gave is well as expected return glect and changes in in staff were reminded that itolerated in the facility and came first. The facility's IJ is allowed to call facility administration in the nurse aides and gave is well as expected return glect and changes in in staff were reminded that itolerated in the facility and came first. The facility's IJ is allowed to call facility administration in the nurse aides and gave is tall as expected return glect and changes in in staff were reminded that itolerated in the facility and came first. The facility's IJ is allowed to call facility administration is the nurse aides and gave is the nur		600			8/3/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED	
	345261	B. WING		C 07/12/2023	
	1		STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	- VIII 2222	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
§483.12(b)(5) Ensur occurring in federally facilities in accordan Act. The policies and but are not limited to §483.12(b)(5)(ii) Poemployee rights, as (3) of the Act. §483.12(b)(5)(iii) Poemployee rights, as (3) of the Act. §483.12(b)(5)(iii) Proposition of the Act. This REQUIREMEN by: Based on observation of the Act. This REQUIREMEN by: Based on observation of the Act and coolinvestigation that incomposition of the Act and the Act	e reporting of crimes y-funded long-term care ce with section 1150B of the d procedures must include the following elements. sting a conspicuous notice of defined at section 1150B(d) ohibiting and preventing d at section 1150B(d)(1) and T is not met as evidenced ons, record reviews, staff and ne facility failed to identify sidents from abuse, and state agency and local law implete a thorough luded staff interviews of orted to have occurred care for 1 of 3 residents wed for abuse. On 02/16/23 opinned Resident #11's arms s when Resident #11 became continent care. After the care ofted to have bruising to her At the conclusion of the lity substantiated abuse but eturn to work to care for other ty. The facility further failed to on 03/19/23 when Resident #1's room and touched her riginal area, the incident was who asked Resident #2 to ent #1 then left Resident #1	F 60	F607 Develop/Implement Abuse/Neglect Policies 1. Resident #11 and Resident #1 continue to reside in the facility, Resident #2 no longer resides at the facility. Resident #1 and Resident #11 have in presented with any signs of mental anguish or psychosocial harm related the reportable incidents. Resident #9 longer resides at the center. 1. Current residents have the potent be affected by this deficient practice. 2. DON and ADON have completed education for staff members on abuse including the various types of abuse (verbal, physical, mental, sexual, neglinvoluntary seclusion, exploitation, misappropriation, resident to resident mistreatment). Education was also	to no tial to e, ect, and	
	CORRECTION OVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENC REGULATORY OR Continued From pag §483.12(b)(5) Ensuroccurring in federally facilities in accordan Act. The policies an but are not limited to §483.12(b)(5)(iii) Poemployee rights, as (3) of the Act. §483.12(b)(5)(iii) Premale and the ending in the end in the ending in the end	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(iii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced	DOVIDER OR SUPPLIER IY CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 53 §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(iii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d) (3) of the Act. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff and resident interviews the facility failed to identify abuse, protect all residents from abuse, and report abuse to the state agency and local law enforcement and complete a thorough investigation that included staff interviews of bruising that was reported to have occurred during incontinence care for 1 of 3 residents (Resident #11) reviewed for abuse. On 02/16/23 Nurse Aide (NA) #10 pinned Resident #11's arms between their bodies when Resident #11 became combative during incontinent care. After the care Resident #11 was noted to have bruising to her bilateral lower arms. At the conclusion of the investigation the facility. The facility further failed to protect Resident #1 on 03/19/23 when Resident #2 entered Resident #1's room and touched her on her breast and vaginal area, the incident was witnessed by NA #1 who asked Resident #2 to stop touching Resident #1 then left Resident #1 and Resident #2 alone and unsupervised in the	DOWNDER OR SUPPLIER IV CENTER SUMMARY STATEMENT OF DEFICIENCIES PREPEIX FROVIDER'S PLAN OF CORRECTIVO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF OT PIEA PAPRORE DEFICIENCY) FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF OT HEAPPRORE DEFICIENCY TAG FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF OT PIEA PAPRORE DEFICIENCY TAG FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF OT PIEA PAPRORE DEFICIENCY TAG FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF OTHER PAPRORE DEFICIENCY TAG FROVIDER'S PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OF OTHER PAPRORE PREPIX TAG FROVIDER'S PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE OT OTHER PAPRORE PREPIX TAG FROVIDER'S PROVIDER'S PROVIDER'	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY
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	345261		B. WING			07/	12/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ALLEGHA	NY CENTER				79 COMBS STREET PARTA, NC 28675		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 607	Continued From page	e 54	F	607			
	· -	ailed to report the sexual			presenting with these behaviors/mood		
		trator on 03/19/23 which			changes should be monitored and the		
	allowed a second inc	ident of sexual abuse on			change reported to their supervisor. In		
	3/20/23 to occur. On	03/21/23 Resident #1			addition, education was provided that t		
	reported the sexual a	buse that occurred on			alleged perpetrator and victim should b	е	
		nd NA #6 who then reported			separated with the perpetrator being		
		he Director of Nursing			monitored. Initial reports should be file		
	(DON) and Administrator. The facility failed to thoroughly investigate the allegation of abuse to ensure all residents were assessed for sexual abuse. This affected 1 of 3 residents reviewed for				with Law Enforcement, Adult protective	;	
					Services and the North Carolina		
					Department of Health and Human Services within the allotted time limits.	۸	
	resident-to-resident a				complete investigation will be conducted		
		isass (resident #1).			within the five-day requirement set by	, u	
	Immediate ieopardy b	pegan on 02/16/23 when the			Federal Regulations. Staff that have no	ot	
		fy, thoroughly investigate,			received the education will be required		
	_	I residents from abuse after			have education prior to the next shift		
	an allegation of staff t	to resident abuse.			worked. New staff will receive the		
		was removed on 06/23/23			preceding education in orientation.		
		ided and implemented an					
		allegation of immediate			3. Chief Nursing Officer or designee	will	
	, , ,	e facility will remain out of			review all reportable events involving		
		r scope and severity E (no			abuse or neglect to ensure all reports a		
	monitoring systems a	ential for harm) to ensure			filed within the allowed time limits set be Federal Regulations, that all investigations	•	
	completion of staff ed				are completed within allowable time lim		
	completion of stall or	addition.			and that all allegations of abuse or neg		
	The finding included:				are thoroughly investigated.		
	A review of the facility	y's policy titled "Abuse			4. Chief Nursing Officer or designee	will	
	-	0/24/22 revealed: Centers			bring findings from the review of files to		
	prohibit abuse, mistre	eatment, misappropriation of			the Quality Assurance Committee mee		
		and neglect. The Center will			monthly for three consecutive months.		
		prohibition program through			The Quality Assurance Committee will		
		gation of incidences and			evaluate the effectiveness of the above		
	allegations. 7. Immed				plan and will make additional interventi	ons	
		ng a report of suspected or			and recommendations based on the		
	_	ministrator will perform the			audits to ensure continued compliance		
		an investigation within 24 of abuse that focuses on:			5. Date of completion August 3, 2023	}	

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	· · · · · · · · · · · · · · · · · · ·	0111212023	
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F 607	7.7.2 clinical examin causative factors. 7. thoroughly documen Portal. Ensure that conterviews is include Further review of the review of the facility' Prohibition" revised prohibit abuse, mistre property, exploitation upon receiving information suspected or alleged perform the following state and local author mental, physical, and hours after the alleged 1. Resident #11 was 11/21/22 with diagnous vascular accident, didementia. A review of the Initian 02/16/23 indicated the abuse incident on Resident #11's right 02/16/23. The Reposition of Resident #102/20/23 for Resident 2/16/23 revealed the Nurse Aide (NA) #9 witnessing the incident the Administrator into statements indicated.	e occurred and to what extent; action of injuries; 7.7.3 8 The investigation will be ated in Risk Management documentation of witnessed d. e facility's policy read: a. A spolicy titled "Abuse 10/24/22 revealed: Centers reatment, misappropriation of an and neglect. 7. Immediately mation concerning a report of diabuse the administrator will g: 7.2 report allegations to orities involving abuse (verbal, disexual) no later than 2 ation is made. I Allegation Report dated and facility became aware of finew discolorations on and left arms at 9:00 AM on art indicated local law stiffied on 02/16/23 at 3:00 PM. Ity Investigation Report dated and the facility and NA #11 abuse that occurred on the accused individual was with NA #10 and NA #11 ant. The report summary read	F 6	07			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	0771212020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION	
F 607	hit, bite and scratch attempting to change she did not hold the during her interaction indicated that she do together so that the Resident without be statements were concerned as were concerned as winging her bed rephysical injury of directly as winging an observation of the was alert bed. Resident #11 on 06 Res	the Resident was attempting to a the staff while they were ge her. NA #9 indicated that a Resident's hands or arms on with Resident #11. NA #10 lid hold Resident #11's hands a staff could finish changing the reing injured. All the staff's ansistent indicating that reeing combative with staff and remote. The incident resulted in recolorations to the Resident rearms. The summary of the that NA #10 did hold down to keep her from hitting and and the incident was A #10 continued to work and other residents. Son and interview with 1/20/23 at 10:10 AM the and talkative while lying in explained that she vaguely cident when two girls, she resident was or any estated she thought it was just	F 607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	0111212020	
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 607	them change her. We the Resident's sheet up her bed remote at which made a loud and called Nurse #76 the Nurse tried to tat NAs change her, but care. They ended ut care. They ended ut care. The NA stated staff members (she they hit her, but the on her left hand. We was interviewed by NA stated that she habout the incident, havite a statement all before she left the formula to 15.2 PM revealed was assigned to Receivas assigned the Receivas assigned to Receivas and extended body and the Resident #11 scratching them so over to facing her, sams and extended body and the Resid Resident from scratinsistent that she dichands and if the Receivas interviewed by	ged and she agreed to let When NA #11 started to pull It down Resident #11 picked and hit NA #11 on her hand Ithud. She stated they stopped If into the Resident's room and If the Resident into letting the If the Resident still refused If not being able to provide If, later Resident #11 told other If could not recall who) that If Resident already had a bruise If nen NA #9 was asked if she If anyone about the situation the If not been interviewed If not been i	F 607			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345261	B. WING			07/	12/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
ALLEGHA	NY CENTER			·	179 COMBS STREET		
ALLEGNA	INT CENTER			,	SPARTA, NC 28675		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 607	Continued From page	a 58	_	607			
1 007				007			
		it the events of the night of t #11 or she would have					
		n how she crossed the					
		e stated she was only asked					
		a statement about the night					
	_	e left that morning. NA #10					
	reported she was sus	•					
		s allowed to go back to work					
		igned to Resident #11. The					
	NA stated the last night she worked at the facility						
	was Friday 06/16/23.						
	On 06/22/23 at 8:15 A	AM during an interview with					
		d she still worked at the					
	facility and the last ni						
	06/21/23. The NA sta	ted she was assigned to					
	Resident #11 on 02/1	6/23 and that they					
	attempted to change	Resident #11 multiple times					
		ift, and multiple times she					
		y the early morning you					
		ne strong urine and fecal					
		nd when the Resident did					
		her, Resident #11 required					
	a brief change includi						
	•	ined NA #10 assisted her					
		continence care and halfway e Resident began to scratch,					
		to bite them while swinging					
		em. She continued to explain					
		sident #11 toward NA #10					
	•	Resident's arms down and					
	lean over her to preve						
		to finish changing her, but					
		e Resident's hands down.					
	NA #11 stated she did	d not notice any bruising on					
	Resident #11's hands	or arms because if she					
	had, she would have	reported it. The NA stated					
		ration had interviewed her					
	about the situation bu	ıt she did write a statement					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345261	B. WING	B. WING		C 07/12/2023			
	ROVIDER OR SUPPLIER			STREET ADDRESS 179 COMBS STR SPARTA, NC 2		1 011	12/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTIC CH CORRECTIVE ACTION SHOULI S-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 607	because it was come accuse the staff of d do. An interview was condo/20/23 at 8:40 PM worked with Resider evening shifts and w 02/15/23 to the morr reported that Reside to her arms and han because the Reside her left arm earlier in the skin tear and had bed and I asked her to pick at the skin tear worse, but she contiins She stated the Reside as well, but she did to because she always explained that night be changed multiple agreed to be changed there to change there to change her allow one aide to probecause of her behad did not know anythin accusations toward is shift until she came I scheduled shift and been "let off" for sev no one from administ the nights events or how Resident #11 ac the Resident's arms	se #6 for her protection mon for Resident #11 to oing things that they did not inducted with Nurse #7 on who explained that she at #11 often during the ras on duty the night of oing of 02/16/23. The Nurse of #11 already had bruising dis before that evening shift in thad pulled a band aid off in the shift and was picking at dit bleeding with blood on her several times that night not far that she was making it induct to pick at the skin tear. Ident had bruising on her arms not report the bruising had bruising. The Nurse Resident #11 had refused to times but at one point she ad so all three NAs went in mainly because they did not ovide care for Resident #11 inviors. The Nurse stated she ag about Resident #11's the nurse aides during that brack to work her next learned that NA #10 had eral days. The Nurse stated tration interviewed her about she would have told them coted and that the bruising on and the skin tear was there in shift the evening of	F	607					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345261	B. WING			C)7/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	8:56 PM the Nurse the night of 02/15/2 Nurse #7 in attending stated she did not rust bruising on Resider Nurse #7 had walke at a sore on her arr Nurse reported that care multiple times changed several times she had instructed Resident's room by because of Resider and false accusation felt that was best for #6 stated that she was accusations made I the NAs that worke back on duty and less uspended because arms in order to roll NA #9 and Nurse # The Nurse stated statements about the them to the Nurse Einterviewed by admisshe would have expendent that she was a finite to the shift. An interview was contained that she was an incident with Resident in attention of the state of the shift.	ge 60 with Nurse #6 on 06/20/23 at confirmed she was on duty 3 to 02/16/23 and assisted ng to Resident #11. Nurse #6 emember or know about any at #11, but she knew that ed in on the Resident picking an and had it bleeding. The Resident #11 had refused even after calling out to be nes that night. Nurse #6 stated the NAs not to go into the themselves to provide care at #11's combative behaviors ans toward the staff and she reveryone's protection. Nurse was not aware of any by Resident #11 against any of d that night until she came earned that NA #10 was as she crossed the Resident's her over to provide care and 7 were in the room at the time. The had the staff write the night's events and gave educator but was never inistration about the events or obtained what happened during onducted with the Unit 16/20/23 at 1:50 PM who did not know any details about sident #11 and NAs #9, #10 at of 02/15/23 to 02/16/23	F 60	7		
	on 02/16/23 to com Resident #11 that s	s asked by the Administrator plete a skin assessment on howed bruising on one of her ldn't remember which hand.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` '	LE CONSTRUCTION		E SURVEY IPLETED
		345261	B. WING		0.	C 7/12/2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		07/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 607	held her hands down explain who they where he did not report to about how the bruit. Administrator was and had interviewed presence. The UM investigate the incite staff about the incite job to do so. An interview was concept to the did not stated she only incidents of abuse continued to explain on abuse from 02/2 included identifying as dealing with the included not provide alone and to alway providing care for his he did not investig on Resident #11 the because that was a indicated the investig on the provident. During an interview Nursing (DON) on reported he was the through most of Feexplained that he rethat she frequently abusive to her and	age 61 sident #11 told her that they wn to change her but did not were. The UM explained that what Resident #11 told her sing occurred because the already aware of the bruising d the Resident during her stated she was not asked to dent, nor did she interview any dent because that was not her onducted with the Nurse (23 at 9:00 PM who explained ager employed at the facility educated the staff after the had occurred. The Nurse in that she educated the staff (17/23 to 02/20/23 which is and reporting abuse as well abusive resident which ing care for Resident #11 s have a least two staff when her. The Nurse insisted that igate the accusation of bruising at happened back in February hot her job to do that. She tigation would have been done dursing at the time of the with the former Director of (06/22/23 at 2:55 PM the DON e acting DON from January bruary 2023. The DON emembered Resident #11 in accused the staff of being they were afraid to go into her re for her, so he had them go	F 60			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345261	B. WING				C 12/2023
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 79 COMBS STREET SPARTA, NC 28675	<u> </u>	12/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	provided. He stated F call light and bed rem them, threatening to linvestigated several i Resident #11 that has staff but not the night remember investigatibruising on Resident stated if he had there documentation of his have assessed the R in Resident 11's chart An interview was con Administrator on 06/2 explained that the stawho) informed him in 02/16/23 that Resider arms and to his know reports of bruising repefore that day. The Nurse Educator information the staff to cross the them in order to make easier for the resident them. The Administration he interviewed Resident see any bruising statement that he wro reported to him that a hands down during control to the staff to constant the interviewed Resident that he wro reported to him that a hands down during control to him that a hands down d	cole and to document the care Resident #11 liked to use her note as a lasso and swing at hit them. The DON stated he noidences involving opened with the daytime time staff and he did not ng anything pertaining to #11 before he left. The DON would have been investigation and he would esident and documented it t.	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		' '	X3) DATE SURVEY COMPLETED				
			A. BOILD			، ا	С
		345261	B. WING				12/2023
NAME OF P	ROVIDER OR SUPPLIER			,	STREET ADDRESS, CITY, STATE, ZIP CODE	1 077	12/2023
	101.52.1 01.1 00.1 2.2.1				79 COMBS STREET		
ALLEGHA	NY CENTER				SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From pag	ge 63	F	607			
		pending the outcome of the					
		se she admitted to holding the					
	_	s down during care even					
		1 stated it was NA #9. The					
	_	the did not personally					
		d staff about the incident or					
	get a verbal explana						
		e the verbal investigation was					
		anager and the Nurse					
		inistrator stated he only					
	reviewed the NAs w						
	all consistent in that Resident #11 was combative						
	during care which m	nade himself and the upper					
	management questi	ion whether it was abuse. He					
		eel it was abuse and					
		not terminate the employee					
		ust have marked the					
		as substantiated by mistake.					
		tated NA #10 returned to work					
		on and continued to work at					
	,	NA #9 and #11. During the					
		istrator was asked how the					
		e other residents who were ccused NA #10 and the					
		inable to explain nor was he					
		nonstration of the other					
	•	n from NA #10 since she					
	-	the facility since the incident					
		ministrator indicated he should					
		prough with investigating the					
		ted that he was unfamiliar how					
		this state coming from				ĺ	
		e had learned that he needed				ĺ	
		and thorough when he				ĺ	
		and report abuse to local law				ĺ	
	_	ate agencies within the 2-hour				ſ	
		ninistrator added he did not				ĺ	
	report the incident to	o the local law enforcement or					
		the two-hour time frame				ĺ	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 179 COMBS STREET SPARTA, NC 28675	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI TO THE APPROPRIA	DATE	
F 607	management to do se permission. The Administrator wajeopardy on 07/12/22. The facility provided. Identify those recipies are likely to suffer, as a result of the noncontext of the noncontex	as notified of the immediate at 4:49 PM. the following IJ removal plan: ents who have suffered, or serious adverse outcome as	F	607			
		ed approximately 1:30 AM loyees did not inform the					

AND DI AN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345261	B. WING			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	1	3111212323
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	incident happened. notified approximate and the incident was 5:24PM. NA #9, NA suspended pending Administrator failed investigate the alleg which led to further. On 3/19/23 Nurse Aroom and witnesser. Resident #1 breast clothing. Nurse Aids stop touching Residing immediately. Nurse #1 failed to into her supervisor as policy. The failure of Administrator led to enforcement, Adult starting an investigation the perpetrator again on 3/20/23 at All facility staff have same deficient praction. On 6/21/23 the Adn days for the last 30 was completed per identified and correspectify the action to process or systems.	Administrator at the time the The Administrator was ely at 9:00AM on 2/16/2023 at seported on 2/	F 6	07		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345261	B. WING _			07/12/2023	
NAME OF F	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP	CODE		
ALLEGU	NIV CENTED			179 COMBS STREET			
ALLEGHA	ANY CENTER			SPARTA, NC 28675			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT		
F 607	current staff includicidentifying and report Director of Nursing Nursing educated of Education included physical abuse, me involuntary seclusion misappropriation of mistreatment. The agency staff, that he will not be able to withis education. The responsible for ensevent abuse is with should stay with the from the abuse. Implication of the Chief Nursing of Should confirm the removed, the perpensitial investigation of department and Additional complete a thoroug submitting the five-were asked to return confirm understand of Nursing will educated hired staff, to include completed 6/21/23. In the event of residents. The char responsible for assistance of the completed to protect residents. The char responsible for assistance in the completed to protect residents. The char responsible for assistance in the completed to protect residents. The char responsible for assistance in the completed to protect residents. The char responsible for assistance in the completed to protect residents. The char responsible for assistance in the completed to protect residents.	orting abuse. On 6/21/23 the and Assistant Director of current staff on Abuse. Verbal abuse, neglect, on, exploitation, fresident property and staff members, to include ave not received the education work until they have received Director of Nursing is uring this is enforced. In the essed the staff member eresident providing protection mediately after removing the aust be reported to the Administrator was educated by Officer on 6/21/23 on how he abuse and potential has been extrator is monitored, submit and to the State, contact the police ault Protective Services and the investigation prior to day report to the State. Staff on information verbally to ling of education. The Director cate in orientation for newly de agency staff. Education	F	607			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345261	B. WING		C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	1 01/12/2023
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 607	Continued From page	2 67	F 60	7	
	6/22/23 by the Director Effective 6/21/2023/2 responsible for ensurimmediate jeopardy mon-compliance. On 06/28/23 a credib Jeopardy removal was reviewed, along incidents in the last the reporting. No addition The education used to nabuse was review sheets to confirm reconducted and staff visteps they should tak any type of abuse. The verbalize that they must the Administrator. The on one-on-one superprotection of other responsible to be a part of all newly hired staff. To verbalize his report frames after becomin suspected abuse in the removal date of 06/23 and revised the suspected abuse patient who has in an	or of Nursing. O22 the Administrator will be ing implementation of this emoval for this alleged de allegation of Immediate is conducted in the facility. Abuse policy and procedure with facility reported with facility reported inty days to ensure timely ital concerns were noted. To re-educate the facility staff ed along with staff sign in eight of the education. Incross the disciplines were were able to verbalize the restaff were able to ust stop the abuse and stay iding protection from the ediately report the abuse to be perpetrator is to be placed wision immediately for the sidents. The education was for the orientation program for the Administrator was able ting requirements and time graware of any witness or the facility. The facility's abuse policy dated on 10/24/22 read in part, if its patient to patient, the y way threatened or the removed from the setting			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG	, ,	OATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	1 0.0201	STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		07/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 607	from further harm do who witnesses an in neglect, or involunta unknown origin, or reproperty is to tell the and report the incide immediately, regard notified supervisor wabuse immediately the designee and other state law. Resident #1 was ad 01/18/23. Review of the signiff Set (MDS) dated 03 #1 had clear speech needs known and was Resident #1 was mad required limited activities of daily livit Resident #2 was ad 04/01/21 with diagnomajor depressive distant others. Review of the quarter revealed that Reside cognitively impaired behaviors, rejection the assessment referequired limited to e activities of daily livit mobility.	atter will protect the patient uring an investigation. Anyone cident of suspected abuse, rry seclusion, injuries of nisappropriation of patient abuser to stop immediately ent to his/her supervisor less of shift worked. The will report the suspected to the Administrator or officials in accordance with mitted to the facility on cant change Minimum Data //13/23 revealed that Resident and was able make her as able to understand others. Inderately cognitively impaired to extensive assistance with mg. mitted to the facility on coses that included anxiety, sorder, vascular dementia, early MDS dated 03/10/23 ent #2 was moderately	F6	507		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		COMPLETED
		345261	B. WING			C
	ROVIDER OR SUPPLIER	340201	STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		07/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	came into her room and kissing her han her breast on top of then tried to touch his stated that she asked did. Resident #1 wa and time the incider assessed for injuries Investigation initiate one-on-one supervisthe Emergency Dep The report was com Nursing (DON). Resident #2 was disfacility on 03/29/23. Review of the facility revealed that Nurse Resident #1 and Nurse Resident #1 resided Nurse Aide (NA) #1 06/20/23 at 2:33 PN caring for Resident that evening Resident that evening Resident room and Resides moking entered Rewheelchair. NA #1 sesident #1's room, wheelchair's facing stated to her, "pleas from my twat", NA # hand was on top of vaginal area. NA #1 Resident #2 to stop did. NA #1 stated th	and started holding her hand d, then proceeded to touch clothing and under clothing er vaginal area. Resident #1 dd Resident #2 to stop, and he is not sure of the exact date it occurred. Resident #1 was is, and none were noted. d. Resident #2 placed on sion. Resident #1 was sent to artment (ED) for evaluation. pleted by the Director of incharged home from the charged home from the charged home from the was caring for its #1 was on the unit where	F 6	07		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	' '	OATE SURVEY COMPLETED
		345261	B. WING _			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		0771272023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	alert Nurse #1 of whomas returning to Resident #2 in the hareturning to his room stated that at the end followed up with Nurdocumented what hat that Nurse #1 stated anything regarding the was consensual. Not think anything about Resident #2 in the rot to report to Nurse #1 removed his hand from She added that she care of what she need incident. Attempted phone into made on 06/20/23 and unsuccessful. A statement provided at 5:00 AM read on 3 med pass, staff repositioned with the statement and had his hand in residents were sitting. This Nurse asked Reand she replied, "so what I want." Reside language and report incident was consent involved. An observation and its returning to the same report incident was consent involved.	cing each other to go and at had occurred. As NA #1 sident #1's room she passed allway in his wheelchair on the same unit. NA #1 d of her shift she had se #1 about if she had ad occurred. NA #1 stated she had not documented he incident because she felt it A #1 stated that she did not leaving Resident #1 and soom together while she went because "he instantly om her when I asked him to." assumed Nurse #1 had taken eded to regarding the erview to Nurse #1 were to 11:12 AM and were	F 6	07		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675		07/12/2023
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	incident with Resider know the date or time room but could not re her wheelchair and Froom and "touched in touch my vagina but She explained that he clothes, but she did in stated she tried to ble because she did not happened to her. Respouse had recently not want another mathat Resident #2 had inappropriate gesture before but again she incident anymore. NA #5 was interviewed who confirmed that significant with the sident told her that Resident told her that Resident told her that Resident #4 what Resident #1 certain that Resident #1 certain that Resident in her eyes" when she happened, and Resident stated that after they stated that after they	I that she recalled the nt #2. She stated she did not be but stated she was in her recall if she was in bed or in Resident #2 came in her ne on my breast and tried to I pushed his hand away." The touched her on top of her not like to talk about it and bock it from her memory like to think about what had resident #1 explained her passed away and she did not ouching her. She added never made an re or passes toward her did not wish to talk about the red on 06/20/23 at 2:07 PM he was caring for Resident sfer of Resident #1, NA #5 #1 had tears in her eyes and to the red on the touched her breasts. The room while NA #6 the room while NA #6 the room while NA #5 was "sad and had tears he told her what had dent #1 made it very clear reported to Nurse #4, she and Administrator, and they	F	507		
		ed on 06/20/23 at 1:04 PM he was caring for Resident				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345261	B. WING		C 07/12/2023	
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	07/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION	
F 607	while transferring F stated that Resider that he should not #1 was very clear stouching her at all. stated that Resider her pants and her had gotten Resider Nurse #1. NA #6 stold her and NA #5 immediately reported DON and Administration. Nurse #4 was inter at 11:52 AM who could be for Resident #1 on Resident #1 on Resident #1 was not she was very upses she normally did. For Resident #2 had stouched her brown immediately came confirmed that she who asked that Resident #1 was not she was very upses and touched her brown immediately came confirmed that she who asked that Resident #2 had stouched her brown asked that Resident #4 had stouched her brown asked tha	ing the day shift. She stated tesident #1 out of bed she at #2 had touched her in places be touching her, and Resident #1 he did not want Resident #2 NA #6 stated that Resident #1 at #2 had touched her inside breast area, and that NA #1 at #1 to stop and reported it to ated that when Resident #1 what had happened, they ed it to Nurse #4 who told the rator and they began an wiewed via phone on 06/20/23 confirmed that she was caring 03/21/23. She stated that quested to get out of bed by and during the transfer of acting like her usual self, and not joking with them like tesident #1 reported that suck his hands down her pants east and NA #5 and #6 and reported to Nurse #4 who went and reported to the DON sident #1 be sent to the ED for the was and returned with no sent recorded by the SW dated questions were asked by the esident #1: Resident #1 in the time that the also tried to play the time that the also tried to play the time. I told him to stop." The	F 60°	7		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	345261	B. WING			C 07/12/2023	
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 179 COMBS STREET SPARTA, NC 28675	I	0//12/2023	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	TION SHOULD BE COMPL THE APPROPRIATE DAT		
Administrator asked Reside had been back, Resident # yesterday. I told him I don't husband was watching him that when he came back, h and kiss her, and she state The Social Worker (SW) wa 06/20/23 at 4:30 PM who stalerted of the incident betw Resident #2 on 03/21/23 ar to interview Resident #1 ald Administrator. The SW stat was not tearful she was "all She recounted the events t come into her room and tou and vaginal area and that stouching her at all. The SW the interview she had intervand oriented residents on the other incidents had occurre reported, and she continue #1 daily for a while after the not say what the facility had interviewable residents, she the DON would know. The DON was interviewed PM who stated that on 03/2 made her and the Administ reports from Resident #1 was Resident #2 had touched he stated that she had gone at assessment of Resident #1 and then had Nurse #4 sen evaluation. The DON stated stated Resident #2 had toutop of her clothes and tried area and she stopped him.	1 stated "yeah, like that. I told him my ." Resident #1 stated e tried to touch her d she felt unsafe. as interviewed on tated that she was een Resident #1 and and she had gone down ong with the ed that Resident #1 most angry and upset." hat Resident #2 had uched on her breast the did not want him a stated that following viewed the other alert he unit to see if any and and none were d to check on Resident e event. The SW could done for the none stated that maybe stated that maybe and only Resident #1 and only Resident #1 and only Resident #1 and her to the ED for d that Resident #1 ched her breasts on to touch her vaginal	F6	507			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345261	B. WING _			C 07/12/2023
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 179 COMBS STREET SPARTA, NC 28675		77712/2020
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 607	03/21/23 at which timinitiated. All staff that interviewed as well a was placed on one-to discharged home a for She stated that she his statement indicating consensual, but she Resident #1 and Nur terminated from the for NA #1 should not have Resident #2 alone to should have immediated removed Resident #2 Nurse #1. The DON have gone up the chartent person in lining respond appropriated abuse, and they have effect. The Administrator was 4:59 PM who stated incident between Residents were separ investigation. He staff through 03/21/23 and he immore sidents were separ investigation. He staff through 03/21/23 to for and what was reported confirmed that he has 03/21/23 and she regin her and room and vaginal area and she Resident #1 reported #2 had again entered	not reported to her until the the investigation was were involved were as the residents, Resident #2 to-one supervision until he we weeks after the incident. The incident was that the incident was the inverted that response from the se #1 was ultimately acility. The DON stated that we left Resident #1 and resident in the room, she wittely stopped the abuse and reform the room then alerted redicated that NA #1 should ain of command and called the when Nurse #1 did not response to the reports of sexual that he was notified of the sident #1 and Resident #2 on rediately made sure the	F 6	07		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345261	B. WING _			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 179 COMBS STREET SPARTA, NC 28675	ODE	1 0111212020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BI HE APPROPRIA	
F 607	local law enforcement to the ED for evaluatic conversation the Adn Resident #1 was very consensual, and she touching her. The Ad once he became awaimmediately began he the staff on immediately began he staff on immediately began he staff on immediately who had been abuse reported and respond not then continue up. The Administrator waigeopardy on 06/21/23 The facility provided and result of the noncord likely to suffer, and a result of the noncord on 3/19/23 Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom and witnessed Resident #1 breast and clothing. Nurse Aidroom Administrator present and Nurse #1 failed to im to her supervisor as of policy. The failure of Administrator led to renforcement, Adult Prestarting an investigation and surface	ministrator stated he notified at and Resident #1 was sent ion and returned. During the ministrator stated that y clear this was not did not want Resident #2 ministrator stated that he are of the incident, he is investigation and educated ely protecting the resident d and ensuring that it was ded to appropriately and if the chain of command. It is notified of the immediate at 8:41 AM. Ithe following IJ removal plan: Ints who have suffered, or serious adverse outcome as impliance. Ide #1 entered Resident #1 Resident #2 touching ind vagina through her #1 asked Resident #2 to ent #1 and he did wide #1 left the room with the indirected by the facility's indirected by the facility's indirected by the facility's indirective Services, not ion, lack of protection, and approached the resident	F	607		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		(X3) DATE SURVEY COMPLETED
	345261	B. WING		C 07/12/2023
NAME OF PROVIDER OR SUPPLIER ALLEGHANY CENTER			179 COMBS STREET	1 01/12/2023
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
All facility staff have same deficient prace. On 6/21/23 the Adn days for the last 30 was completed per identified and corre. Specify the action the process or system adverse outcome from when the action will limital education was current staff including identifying and report of Nursing Nursing educated of Education included physical abuse, me involuntary seclusion misappropriation of mistreatment. The sagency staff, that havill not be able to withis education. The responsible for ensievent abuse is with should stay with the from the abuse. Immabuse the abuse madministrator. The sagency staff, the chief Nursing Coshould confirm the aremoved, the perpendintial investigation to	the potential to repeat the stice. Ininistrator reviewed 24 hour/5 days to identify if reporting policy. There was one issue oted. The entity will take to alter the failure to prevent a serious om occurring or recurring, and I be complete: Is completed on 3/22/23 with a gagency regarding orting abuse. On 6/21/23 the and Assistant Director of current staff on Abuse. Verbal abuse, sexual abuse, notal abuse, neglect, on, exploitation, resident property and staff members, to include ave not received the education fork until they have received Director of Nursing is uring this is enforced. In the essed the staff member are resident providing protection mediately after removing the ust be reported to the Administrator was educated by officer on 6/21/23 on how he abuse and potential has been attrator is monitored, submit an to the State, contact the police	F 60	7	
	ROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY O Continued From pa All facility staff have same deficient prace On 6/21/23 the Adn days for the last 30 was completed per identified and corre Specify the action the process or system the adverse outcome for when the action will Initial education was current staff including identifying and report Director of Nursing Nursing educated of Education included physical abuse, me involuntary seclusic misappropriation of mistreatment. The sagency staff, that have will not be able to we this education. The responsible for ensignees the abuse in should stay with the from the abuse. Im administrator. The administrator. Th	TORRECTION IDENTIFICATION NUMBER: 345261 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 76 All facility staff have the potential to repeat the same deficient practice. On 6/21/23 the Administrator reviewed 24 hour/5 days for the last 30 days to identify if reporting was completed per policy. There was one issue identified and corrected. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Initial education was completed on 3/22/23 with current staff including agency regarding identifying and reporting abuse. On 6/21/23 the Director of Nursing and Assistant Director of Nursing educated current staff on Abuse. Education included verbal abuse, sexual abuse, physical abuse, mental abuse, neglect, involuntary seclusion, exploitation, misappropriation of resident property and mistreatment. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. The Director of Nursing is responsible for ensuring this is enforced. In the event abuse is witnessed the staff member should stay with the resident providing protection from the abuse. Immediately after removing the abuse the abuse must be reported to the Administrator. The Administrator was educated by the Chief Nursing Officer on 6/21/23 on how he should confirm the abuse and potential has been removed, the perpetrator is monitored, submit an initial investigation to the State, contact the police department and Adult Protective Services and complete a thorough investigation prior to	ROVIDER OR SUPPLIER INTY CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 76 All facility staff have the potential to repeat the same deficient practice. On 6/21/23 the Administrator reviewed 24 hour/5 days for the last 30 days to identify if reporting was completed per policy. There was one issue identified and corrected. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Initial education was completed on 3/22/23 with current staff including agency regarding identifying and reporting abuse. On 6/21/23 the Director of Nursing aducated current staff on Abuse. Education included verbal abuse, sexual abuse, pelject, involuntary seclusion, exploitation, milisappropriation of resident property and mistreatment. The staff members, to include agency staff, that have not received the education will not be able to work until they have received this education. The Director of Nursing is responsible for ensuring this is enforced. In the event abuse is witnessed the staff member should stay with the resident providing protection from the abuse. Immediately after removing the abuse the abuse must be reported to the Administrator. The Administrator was educated by the Chief Nursing Officer on 6/21/23 on how he should confirm the abuse and potential has been removed, the perpetrator is monitored, submit an initial investigation to the State, contact the police department and Adult Protective Services and complete a thorough investigation prior to

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED		
		345261	B. WING			C
	ROVIDER OR SUPPLIER	343201	B. Wille	STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	l	07/12/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	confirm understandi of Nursing will educe hired staff, to include completed 6/21/23. In the event of resid perpetrator will be pa medical/psychiatric completed to protect residents. The charger responsible for assignurses were notified 6/22/23 by the Direct Effective 6/21/2023 responsible for ensummediate jeopardy non-compliance. Alleged Date of IJ Real A credible allegation removal was conduct The facility's current was reviewed, along incidents in the last reporting. No addition the education used was reviewed along confirm receipt of the staff across the discess that were able to vertake if they witness. The staff were able stop the abuse and providing protection immediately report to	in information verbally to any of education. The Director ate in orientation for newly e agency staff. Education ent-to-resident abuse the laced on a 1:1 monitoring until c evaluation can be the victim and all other ge nurse on duty is gning the 1:1 monitor. Charge of this responsibility on the Administrator will be uring implementation of this removal for this alleged	F 6	07		

	AND DEAN OF CORRECTION IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED	
							С
		345261	B. WING _			07/	12/2023
	ROVIDER OR SUPPLIER NY CENTER			STREET ADDRESS, CITY, STATE, ZIP (179 COMBS STREET SPARTA, NC 28675	CODE		
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F 607 F 867 SS=D	other residents. The eapart of the orientation hired staff. The Admin verbalize his reporting frames after becomin	ely for the protection of education was verified to be on program for all newly histrator was able to g requirements and time g aware of any witness or the facility. The facility's 8/23 was validated.		867			8/3/23
33-0	§483.75(c) Program finonitoring. A facility must establic policies and procedure collections systems, a adverse event monitor procedures must include following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representative information will be us are high risk, high volopportunities for impression from all dimot limited to the facil §483.70(e) and include stable in the stable in the facil systems to identify, or information from all dimot limited to the facil systems to identify.	feedback, data systems and sh and implement written res for feedback, data and monitoring, including bring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and wes, including how such ed to identify problems that lume, or problem-prone, and					
	§483.75(c)(3) Facility and evaluation of per	development, monitoring, formance indicators,					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPARTMENT OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345261	B. WING _			C 07/12/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	<u> </u>	07/12/2023
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 867	development, monitor §483.75(c)(4) Facility including the method systematically identificanalyze and use data adverse events in the facility will use the daprevent adverse eve §483.75(d) Program systemic action. §483.75(d)(1) The facility and track performance implementing those and track performance implements are respectively. The facility will use determine underlying impacting larger syst (ii) How they will use determine underlying impacting larger syst (iii) How they will dev will be designed to elevel to prevent qualisafety problems; and (iii) How the facility wor its performance improver §483.75(e) Program §483.75(e) Program	lology and frequency for such bring, and evaluation. y adverse event monitoring, is by which the facility will fy, report, track, investigate, a and information relating to be facility, including how the lata to develop activities to ints. systematic analysis and cility must take actions be improvement and, after actions, measure its success, be to ensure that alized and sustained. cility will develop and didressing: a systematic approach to grauses of problems be ems; elop corrective actions that affect change at the systems ty of care, quality of life, or a fill monitor the effectiveness approvement activities to ments are sustained.	F 8	67		

	ND PLAN OF CORRECTION INTERPRETATION NUMBER:		` '	PLE CONSTRUCTION IG	, ,	COMPLETED		
		345261	B. WING _			C 07/12/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 179 COMBS STREET SPARTA, NC 28675	.	0111212023		
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F 867	of problems in those outcomes, resident services resident services, and \$483.75(e)(2) Performativities must track resident events, and implement preventive that include feedbace facility. §483.75(e)(3) As partimerovement activities distinct performance number and frequent conducted by the fact and complexity of the available resources, assessment required annually a project the problem-prone areas collection and analys (c) and (d) of this see §483.75(g) Quality at \$483.75(g)(2) The quassurance committee governing body, or defunctioning as a governing body activities, including in program required un (e) of this section. The (iii) Develop and implementations are settled.	ce, prevalence, and severity areas; and affect health safety, resident autonomy, quality of care. mance improvement medical errors and adverse lyze their causes, and e actions and mechanisms k and learning throughout the conduct improvement projects. The coy of improvement projects illity must reflect the scope e facility's services and as reflected in the facility at §483.70(e). It is must include at least at focuses on high risk or is identified through the data sis described in paragraphs cition. Sessesment and assurance. Luality assessment and de reports to the facility's esignated person(s) erning body regarding its mplementation of the QAPI der paragraphs (a) through	F 8	67				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		345261	B. WING		C 07/12/2023	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	•	71272020
				179 COMBS STREET		
ALLEGHA	NY CENTER			SPARTA, NC 28675		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 867	Continued From page	e 81	F8	67		
F 867	(iii) Regularly review data collected under resulting from drug re available data to mak This REQUIREMENT by: Based on observation interviews, the facility Assurance (QAA) corrimplemented procedu interventions the comfollowing the recertific conducted on 09/14/2 deficiency that was on Resident Rights (F58 recited on the current survey of 07/12/23. The two federal surveys of the facility's inability the program. The findings included This tag is cross referenced an acute 06/13/23 as describe	and analyze data, including the QAPI program and data agimen reviews, and act on the improvements. This is not met as evidenced the same and maintain the failed to maintain the put into place the put in	F8	1. The Quality Assurance Comet and reviewed the purpose function of the Quality Assurance Performance Improvement (Q/Committee as well as reviewed on-going compliance issues re F580 on 7/25/23 2. Current residents are affecturrent deficiency. 3. The Regional Director of Ceducated the Administrator and Nursing on the appropriate funthe QAPI committee and the pthe Committee to include identissues and correct repeat deficiency and correct repeat deficiency. 4. On 7/25/23 the Regional I Operations educated the QAPI members consisting of the Members consisting of the Members and correct repeat deficiency.	ommittee and ace API) d the garding cted by the Operations d Director of ctioning on urpose of difying ciency Director of I committee dical	
	a change in urinary c	r, struggling to breathe, and ontinence and as described and up and down all night		Director, Administrator, Director o Nursing, Assistance Director o Unit Manager, Dietary Manage	f Nursing,	
	· ·	riewed for notification of		of Rehabilitation, Social Worke		
		later Resident #9 was found		Receptionist and HR Manager		
	•	wheelchair in cardiac arrest.		(minimum quarterly), on a wee		
	-	in the facility on 06/13/23.		review of audit findings for con		
	. tooldont #0 expired i	a.o idomity on oor 10/20.		and/or revision needed. QAPI	•	
	During the recertificat	tion and complaint survey of		team members were educated		
		ailed to notify the Physician		meeting agenda, information e		
	55/ 1 1/22 the lability le	and to floury the rangelolari			4011	

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
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SPARTA, NC 28675	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867 Continued From page 82 F 867	
of medication unavailability for 1 of 1 resident (Resident #38) reviewed for pain. The Administrator was interviewed on 06/22/23 at 4:14 PM who stated that the QA committee met monthly and included all the department heads in the facility along with the consultant pharmacist who attended quarterly. The Administrator stated that he directed the meeting and followed an agenda that he had put into place. He stated that the committee would identify a goal and put a plan into place then discuss it until they achieved their desired results. The Administrator could not say if the facility currently had any performance improvement plans in place but stated that any repeat citations he received would be starting from scratch and building a plan, then monitoring the plan to achieve the compliance they desired. F 867 individual is to provide, discussion, planning and the intent of the committee's meeting. In addition to the QAPI committee will continue to meet monthly. 5. The Quality Assurance Committee will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to the repeat deficiency. The monitoring procedure to ensure the plan of correction is effective and the specific cited deficiency remains correct and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility's progress, review corrective actions and date of completion. The Administrator will be responsible for ensuring QAPI committee will continue to meet monthly. 6. Date of completion August 3, 2023.	