DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NC	<u>). 0938-0391</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDI	NG _			
		345381	B. WING				C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	17/2025
					440 INGRAM ROAD		
VILLAGE	CARE OF KING			I	KING, NC 27021		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
TAG	REGULATORT ORT		TAG		DEFICIENCY)		
					-		
F 000	INITIAL COMMENTS		F	000			
	An unannounced on	site complaint investigation					
		d from 01/08/25 through					
		information was obtained					
	offsite on 01/17/25. 1	Therefore, the exit date was					
	changed to 01/17/25.	Event ID #KGG611.					
	.						
	The following intakes investigated:NC0022						
	NC00225160, and NC						
		500220020.					
	3 of the 4 complaint a	Illegations resulted in a					
	deficiency.						
F 580		jury/Decline/Room, etc.)	F	580)		
SS=D	CFR(s): 483.10(g)(14	.)(i)-(iv)(15)					
	§483.10(g)(14) Notific	nation of Changes					
		ediately inform the resident;					
		ent's physician; and notify,					
		her authority, the resident					
	representative(s) whe						
		ing the resident which					
		as the potential for requiring					
	physician intervention						
	mental, or psychosoc	ge in the resident's physical,					
		n, mental, or psychosocial					
		reatening conditions or					
	clinical complications	-					
	(C) A need to alter tre	atment significantly (that is,					
	a need to discontinue	-					
		erse consequences, or to					
	commence a new for						
	(D) A decision to tran resident from the faci	-					
	§483.15(c)(1)(ii).						
		fication under paragraph (g)					
		the facility must ensure that					
					<u> </u>		
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITLE		(X6) DATE

Electronically Signed

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

02/04/2025

		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 02/10/202 RM APPROVE <u>IO. 0938-03</u> 9
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				TE SURVEY MPLETED
		345381	B. WING _			0	C 1/17/2025
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				440	INGRAM ROAD		
VILLAGE	CARE OF KING			KI	NG, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580	all pertinent informati is available and provi physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483. ² (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must fu update the address (f phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on record rev Medical Director inter notify the physician o of 3 residents (Reside notification of change was lifted manually b from the shower chai	on specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, n or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph a. record and periodically mailing and email) and resident osite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct by the policies that apply to en its different locations T is not met as evidenced iew, and resident, staff, and rviews, the facility failed to of a change in condition for 1 ent #1) reviewed for es. On 10/22/24 Resident #1 y Nursing Assistant (NA) #1 r to the bed, causing	F	580	Past noncompliance: no plan of correction required.		
	caught in between the causing severe pain a Nurse #1, was notifie	g to hit the shower chair, get e shower chair and the bed, and swelling. On 10/22/24 ed by NA #1 that Resident #1 Nurse #1 did not notify the					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 02/10/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_	(01/'	C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	• • •	11/2020
			44	40 INGRAM ROAD			
VILLAGE	CARE OF KING		к	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	by Resident #1 of her not notify the physicia who worked from 11:0 (10/23/24), was notifie resident complained of physician. On 10/23/2 from 7:00 am to 11:00 (Unknown) that reside Nurse #4 did not notif Findings included: Resident #1 was adm 05/22/23 with diagnos contracture, spondylo a vertebra in the spine the bone below it), sp the spinal canal that of hypertension (HTN). Resident #1's quarter dated 08/30/24 reveal intact. An interview was cone 01/08/25 at 1:15 pm. she recalled when he #1 indicated that NA # her a shower and had room. Resident #1 indicated walk. Resident #1 indica	24, Nurse #2, was informed right leg hurting, and did in. On 10/23/24, Nurse #3, 00 pm (10/22/24) to 7:00 am ed by NA (Unknown) that of pain, and did not notify the 24, Nurse #4, who worked 0 pm, was notified by NA ent complained of pain. by the physician.	F 580				

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	-	D HUMAN SERVICES					FORM): 02/10/2025 MAPPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345381	B. WING			_		C 17/2025
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	• • •	11/2020
					40 INGRAM ROAD			
VILLAGE	CARE OF KING				(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	bed, Resident #1's rig stuck between the she Resident #1 indicated that she was hurting. NA #1 proceeded with the transfer, even afte was in severe pain of least pain and 10 beir imaginable). Resident completed the transfe she did not fall during indicated that no nurs after she had reported in severe pain. Resided later, the pain got wor it. Resident #1 indicate about her pain getting indicated at that time, assess her and that N who assessed her rig that her pain was 10/7 that Nurse #5 notified an x-ray that revealed #1 indicated that she and opted to be seen Resident #1 indicated orders for additional p severe pain in her rig! A telephone interview on 01/10/25 at 9:08 a worked from 7:00 am provided care to Resi 10/22/24, Resident #1 transfer her back to b	ht leg hit the chair and got ower chair and bed. I that she informed NA #1 Resident #1 indicated that a lifting her manually during er informing her that her leg a 10/10 (with 0 being the og the worst pain #1 indicated NA #1 r and placed her in bed and the transfer. Resident #1 e came in to assess her d to NA #1 that her leg was ent #1 indicated that 2 days se, and she could not bear ed that she informed could not recall name) worse. Resident #1 Nurse #5 came in to lurse #5 was the only nurse ht leg. Resident #1 indicated 10. Resident #1 indicated 10. Resident #1 indicated 11. Resident #1 indicated 12. Sesident #1 indicated 13. Sesident #1 indicated 14. She had fracture. Resident refused to go to the hospital by an orthopedic doctor. that she received new that medication for the nt leg. was conducted with NA #1 m. NA #1 indicated that she to 3:00 pm on 10/22/24 and dent #1. NA #1 stated on 1 had a shower scheduled. she completed the shower,	F	580				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED C
345381 B. WING	01/17/2025
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIF	
440 INGRAM ROAD	
VILLAGE CARE OF KING KING, NC 27021	
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OFPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIX(EACH CORRECTIVE ATAGREGULATORY OR LSC IDENTIFYING INFORMATION)TAGCROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 580 Continued From page 4 the shower chair to the bed, by lifting her manually, with Resident #1's feet not touching the floor. NA #1 indicated that she placed Resident #1 on the bed. NA #1 indicated that she placed Resident #1 on the bed. NA #1 indicated that after completion of the transfer and Resident #1 was in bed, Resident #1 verbalized that her leg was hurting but she was fine. NA #1 indicated that she reported to Nurse #1 that Resident #1 complained that her leg was hurting. NA #1 indicated that ther gave shurting. NA #1 indicated that her gave shurting. NA #1 indicated that Nurse #1 did not go to assess Resident #1 or ask Resident #1 about the pain. An interview was conducted with Nurse #1 on 01/09/25 at 12:11 am. Nurse #1 indicated that on 10/22/24 NA #1 reported that while giving Resident #1 a shower, Resident #1 stated her leg was hurting. Nurse #1 further stated that he went to Resident #1's room and asked if she was in pain, for which Resident #1 tated "no". Nurse #1 indicated he did not assess Resident #1 because he "did not see any reason to do anything further", when Resident #1 had stated she was not in pain. Nurse #1 indicated that he did not notify the physician because he did not assess Resident #1. A telephone interview with Nurse #2 was conducted on 01/09/25 at 2:44 pm. Nurse #2 confirmed she worked on 10/22/24 between 3:00 pm to 11:00 pm and was assigned to Resident #1. Nurse #2 indicated Resident #1 reported to her that when the NA that gave her a shower was putting her to bed Resident #1's nome on the go got caught in the wheelchair and the bed and her right leg was hurting. Nurse #2 did not report the incident to the administration becauses she did not have a way of notifying them. Nurse #2 stated she put Resident #1's name on the medical director's book for "them to follow up" the next	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345381	B. WING				C /17/2025
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VILLAGE	CARE OF KING				440 INGRAM ROAD KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	assess Resident #1 a bruising or swelling. N which leg she assess she had written in the Progress note dated 10/23/24 at 3:04 am i nurse to the room, res- right leg. Resident #1 minutes prior. Applied in reach. Bed in lowes monitor." Multiple attempts mad interview were unsuce Review of progress n pm, written by Nurse #1 has no complaints continue to monitor." A telephone interview conducted on 01/09/2 indicated that she red 10/23/23, that Reside Nurse #4 stated that se #1 if she was having she felt pretty good. N did not assess the leg physician because sh report or notify about A progress note dated written by Nurse #5 re medication pass auth lidocaine patch to righ Resident #1 what hap	e #2 indicated that she did and that she did not see any Nurse #2 could not recall ed for Resident #1 or what medical director's book. written by Nurse #3 on indicated that "NA called this sident complained of pain to had taken Tramadol 30 d ice and elevated. Call light st position. Will continue to de to reach Nurse #3 for an cessful. ote dated 10/23/24 at 4:04 #4, indicated that "Resident of pain at this time, will with Nurse #4 was 25 at 12:29 pm. Nurse #4 alled an NA notified her on int #1's ankle was hurting. she went in to ask Resident pain, and Resident #1 stated Nurse #4 indicated that she g and did not notify the ise did not have anything to Resident #1. d 10/24/24 at 10:41 am evealed that "during morning or noted new medication for	F	580			

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/10/2025 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_	(01/	C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	CARE OF KING		4	440 INGRAM ROAD			
VILLAGE			1	KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	since. Author asked F has been, and Reside but once she got her p better and was able to is having trouble flexin Author removed cover discolored. Author ask and is able to do so s present. Nurse Practif for x-ray to site. Power aware. Resident #1 m elevated as tolerated Resident #1 stated the reach." On 10/24/24 at 10:41 x-ray 2 view" was obta results received on 10 revealed "acute appear fracture." A progress note dated indicated "86-year-old seen today for right til yesterday (10/24/24) and pain to right ankled demonstrating fracture hospital however she orthopedic referral. As boot to be placed and thankful for pain medi Tuesday (10/22/24) h being transferred and on/off since but that it Multiple attempts wer	a caught when being g has been hurting on/off Resident #1 how her pain ent stated it hurt last night pain medication she felt o rest and this morning she ng her toes to right leg. r, right ankle noted, swollen, ked resident to wiggle toes lightly. Pedal pulses tioner (NP) made aware, ok er of Attorney (POA) made nade aware of order. Foot and cold compress applied. at felt good. Call bell within am, order for "right ankle ained by Nurse #5. X-ray 0/24/24 at 3:46 pm that aring distal tibia/fibula d 10/25/24 written by the NP d female patient is being bia/fib fracture. Contacted about increased swelling e and x-ray was ordered e. Patient is refusing the is okay with a stat sked physical therapy for l it is present. Patient is iccations. Resident stated on er leg got caught when her leg has been hurting was an accident." e made to reach NP for an	F 580				
	boot to be placed and thankful for pain medi Tuesday (10/22/24) h being transferred and on/off since but that it	I it is present. Patient is cations. Resident stated on er leg got caught when her leg has been hurting was an accident." e made to reach NP for an					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	2: 02/10/2025 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_	(01/	; 17/2025
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VILLAGE	CARE OF KING			40 INGRAM ROAD (ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	7	F 580				
	interviewed about Res Director indicated that #1 at the time of the fin NP's assessment that Medical Director states the Resident #1 comp 10/22/24 but was awa made on 10/24/24. T indicated that he would notify the physician w An interview with Reg conducted on 01/09/2 Nurse Consultant indi first nurse to notify the Nursing (DON) and he Resident #1 had x-ray a right tibia fracture. T Consultant stated Nur and Nurse #4 did not Regional Nurse Cons not have any record of nurse notifying the ph the medical director's complaints of pain. Th Consultant indicated t physician in reference condition was initially 10/24/24. An interview was cond Administrator on 01/1 Administrator indicated	Id have expected staff to ith a change of condition. ional Nurse Consultant was 5 at 2:18 pm. The Regional cated that Nurse #5 was the e previous Director of erself on 10/24/24 that results indicating she had 'he Regional Nurse rese #1, Nurse #2, Nurse #3 notify the physician. The ultant further stated they did of Nurse #2 or any other ysician or documenting in book about Resident #1's he Regional Nurse hat notification to the e to Resident #1's change of made by Nurse #5 on					

Facility ID: 923523

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/10/2025 1 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345381	B. WING		_	01/ ⁻	C 17/2025
NAME OF PR	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
	CARE OF KING		4	40 INGRAM ROAD			
VILLAGE	CARE OF KING			(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	8	F 580				
	The facility provided t action plan.	he following corrective					
	Address how correctiv accomplished for thos been affected by the o	se residents found to have					
	#1 using stand and pi resident's leg got cau resident reported pair nurse aide did not not resident was transferr not notify the nurse th caught in the shower reported pain. The lice	ght in shower chair, and the n to the nurse aide. The tify the nurse that the red stand and pivot and did nat the resident's leg was chair and the resident					
	provider since the even shift. On 10/23/24 the the resident reported	e but did not notify the ent did not happen on their licensed nurse noted that pain to their leg and was isting as needed Tramadol					
	order, but did not noti change in condition. T						
	the change in condition in leg pain. New order of the right leg. On 10 notified of the results a right distal tibia/fibul						
		to go to the hospital and a appointment was made for					
	Address how the facil	ity will identify other					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM): 02/10/2025 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_	01/ [,]	C 17/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				440 INGRAM ROAD			
VILLAGE	CARE OF KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page residents having the p the same deficient pra On 10/24/24 the Admi interviewed all alert at have been transferred they have any unrepor condition. On 10/24/2 designee assessed al unreported injuries or other issues were idea Address what measur systemic changes ma deficient practice will On 10/24/24 the Direct educated all facility lic nurse aides and all ag certified nurse aides on notification to the nurs condition notification t was provided verbally educated to check the documentation of noti if there is no documer and document the not educated to notify the change of condition w as soon as new pain i immediately inform th nurse if there was a s pain, like an issue witt able to work until they new and agency licen	9 potential to be affected by actice: inistrator or designee nd oriented residents if they appropriately by staff and if rted injuries or changes in 4 the Director of Nursing or I non-alert residents for new changes in condition. No ntified. res will be put into place or de to ensure that the not recur: ctor of Nursing or Designee ensed nurses and certified gency licensed nurses and on change of condition se and timely change of o the provider. Education and in writing. Nurses were	F 58				
	-	e Scheduler will track that agency staff have been					

Facility ID: 923523

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		D HUMAN SERVICES				FORM): 02/10/2025 MAPPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′	E CONSTRUCTION		(X3) DATE	D. 0938-0391 SURVEY LETED
		345381	B. WING		_		C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			4	40 INGRAM ROAD			
VILLAGE	CARE OF KING			(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	- 10	F 580				
	Indicate how the facili performance to make sustained:	ty plans to monitor its sure that solutions are					
	Administrator, Minimu Therapy Director, Bus Medical Records, Dire Housekeeping, Mainte Payroll on 10/28/24 to	meeting was held with the Im Data Set Coordinator, siness Office Director, ector of Nursing, enance, Admissions, and					
	designee will complet on 3 residents per we changes in condition. weeks. Results of the the QAPI committee a will be edited as need						
	Alleged Compliance of	late: 10/29/24					
	The facility's correctiv by the following:	e action plan was validated					
	validated upon review in-service education p nurses and certified n condition notification t change of condition n Review of the monitor concerns identified.	ty's plan of correction was of the sign-in sheets for provided to all licensed urse aides on change of the nurse and timely otification to the provider. Fing audits revealed no					
	Interviews conducted	with licensed nurses and					

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	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
			A. DOILDING		с
		345381	B. WING		01/17/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				440 INGRAM ROAD	
VILLAGE	CARE OF KING			KING, NC 27021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
F 580	education on the cha to the nurse and time notification to the pro correction was valida sign-in sheets for in- all licensed nurses a notification of change review of sampled re changes in condition	revealed they had received ange of condition notification ely change of condition ovider. In addition, the plan of ated upon review of the service education provided to and certified nurse aides on e in condition policy. Record esidents who recently had revealed no concerns. The 0/29/24 for the corrective	F 58	0	
F 684 SS=D	Quality of Care CFR(s): 483.25		F 68	4	2/7/25
	applies to all treatment facility residents. Base assessment of a residents receive accordance with pro- practice, the compre- care plan, and the resident This REQUIREMENT by: Based on record rev Medical Director inter complete and docum assessments after R which delayed medic interventions for 1 of reviewed for assess	undamental principle thatent and care provided tosed on the comprehensivedent, the facility must ensuree treatment and care infessional standards ofhensive person-centeredsidents' choices.T is not met as evidencedview, and resident, staff andrviews, the facility failed tonent ongoing comprehensiveesident #1 reported leg paincal treatment and3 residents (Resident #1)nents. On 10/22/24 Resident		Step 1 Resident remains in the facility. She transfers with the mechanical lift and longer having pain related to the frac Step 2 On 1/30/25 the Director of Nursing of designee reviewed the last two weel progress potes and events for cham	d is no cture. or ks of
	assessments after R which delayed medic interventions for 1 of reviewed for assess #1 was lifted manual #1 from the shower of Resident #1 right leg caught in between th	esident #1 reported leg pain cal treatment and 3 residents (Resident #1)		longer having pain related to the frac Step 2 On 1/30/25 the Director of Nursing c	cture. or ks of ges in eted a hanges out a

L

Facility ID: 923523

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						10.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	E SURVEY IPLETED
			A. BUILDING			С
		345381	B. WING		0,	1/17/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
_				440 INGRAM ROAD		
VILLAGE	CARE OF KING			KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETIO DATE
F 684	Continued From pag	e 12	F 68	4		
		am, Nurse #1 was notified by		discussed with the prov	vider. On 2/4/25 all	
		#1 complained of pain and		alert and oriented resid		
		plete an assessment. Nurse		interviewed if they have		
	#2 was assigned to F	Resident #1 on 10/22/24 from		of condition, staff who h	nave worked in the	
		and did not complete a		last 24 hours were inter	-	
	comprehensive asse			aware of any changes i		
		not observe any bruising or		medical record was rev		
		(assigned to Resident #1 on		comprehensive nurse a		
		n to 7:00 am on 10/23/24) ned to Resident #1 10/24/24		issues identified a compassessment was comp		
		0 pm) were notified by an NA		provider was notified.		
	that Resident #1 was			Step 3		
		nts of Resident #1's right		On 1/30/25 the Director	r of Nursing or	
		sident #1 reported right leg		designee educated all I	-	
	pain to Nurse #5 who	assessed the resident and		that a comprehensive n	urse assessment	
	noted Resident #1's	•		must be completed and		
	discolored and notifie	ed the physician.		the electronic medical r provider must be notifie		
	Findings included:			change in condition. An who did not receive this	y licensed nurse	
	Resident #1 was adn	nitted to the facility on		1/30/25 will receive this	education prior to	
		sis that included right hand		their next shift. All new	hired licensed	
		olisthesis (a condition where		nurses will receive this	•	
		e slips out of place and onto		orientation. All agency I		
		pinal stenosis (narrowing of		receive this education p assignment. The IDT st	•	
	hypertension (HTN).	occurs over time), and		and observe residents		
				rounds for changes in c		
	Review of physician	orders revealed on 4/01/24		review for a compreher		
		cribed Tramadol 50mg		assessment during clini		
	(milligrams) three tim	es a day for pain.		Step 4	-	
				Beginning the week of 2		
	· ·	rly Minimum Data Set (MDS)		of Nursing or designee		
		aled she was cognitively		resident records per we		
	intact.			condition and to ensure		
	An interview was car	nducted with Resident #1 on		completed a comprehe		
		Resident #1 indicated that		and notified the provide Nursing or designee wi		
	ι υ που/ζυ αι τ. τυ μπ.		1			1

Facility ID: 923523

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			0			<u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY
			A. BUILDING	G		0
		345381	B. WING			С
	ROVIDER OR SUPPLIER	343301		STREET ADDRESS, CITY, STATE, ZI		1/17/2025
INAIVIE OF P	ROVIDER OR SUPPLIER				CODE	
VILLAGE	CARE OF KING			440 INGRAM ROAD KING, NC 27021		
				-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIOI DATE
F 684	Continued From page	e 13	F 68	34		
		#1 had just finished giving		of condition and audit that	at there was a	
		d returned Resident #1 to the		comprehensive assessm		
		dicated that she was on the		The Director of Nursing of		
	shower chair, when N	IA #1 lifted her manually to		interview five staff and five		
	transfer her back to b	ed. Resident #1 indicated		week for changes in con	ditions and audit	
		d her by using NA #1's two		that a comprehensive as		
		sident #1's underarms and		been completed. Audits	will continue for	
	-	ver chair onto the bed.		12 weeks.		
		t that she could not stand or licated that when NA #1		Results of these audits w		
		om the shower chair to the		before the Quality Assurated Performance Committee		
		ght leg hit the chair and got		monitoring or modificatio	•	
	stuck between the sh			monthly for three months	•	
		that she informed NA #1		Assurance and performa		
	that she was hurting.	Resident #1 indicated that		Committee can modify th		
	NA #1 proceeded with	h lifting her manually during		the facility remains in cor	mpliance.	
		er informing her that her leg		The Director of Nursing v	vill be	
		a 10/10 (with 0 being the		responsible for implement	ntation of the	
	least pain and 10 bei			plan.		
	imaginable). Residen			Date of Compliance: 2/7/	2025	
		er and placed her in bed and				
		the transfer. Resident #1 se came in to assess her				
		d to NA #1 that her leg was				
		ent #1 indicated that days				
		rse, and she could not bear				
	it. Resident #1 indicat					
	another NA (Resident	t could not recall name)				
	about her pain getting	g worse. Resident #1				
	indicated at that time,					
		Nurse #5 was the only nurse				
	-	ht leg. Resident #1 indicated				
	-	10. Resident #1 indicated				
		I the provider, who ordered				
	-	d she had fracture. Resident refused to go to the hospital				
		by an orthopedic doctor.				
		that she received new				
	orders for additional p					

Facility ID: 923523

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	2: 02/10/2025 APPROVED 0: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING			_	(01/	C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				44	40 INGRAM ROAD			
VILLAGE	CARE OF KING			к	ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	NA #1 gave Resident transferred her to bed room. At this time and but proceeded to tell I was ok and not to wol and NA#1 did report in A telephone interview on 01/10/25 at 9:08 a worked from 7:00 am provided care to Resi 10/22/24, Resident #1 NA #1 indicated, after she took Resident #1 transfer her back to b #1 indicated that she from the shower chair manually, with Resider	nt leg. m NA #1, with no date ed. The statement stated, "I #1 a shower and with another NA in the Resident #1 said she hurt NA#1 that she (Resident#1) rry. Resident #1 was fine, t to the nurse." was conducted with NA #1 m. NA #1 indicated that she to 3:00 pm on 10/22/24 and dent #1. NA #1 stated on I had a shower scheduled. she completed the shower, back to her room, to ed at around 11:00 am. NA transferred Resident #1 t to the bed, by lifting her ent #1's feet not touching the	F	684		JEFICIENCY)		
	#1 on the bed. NA #1 completion of the tran bed, Resident #1 vert hurting but she was fi she reported to Nurse complained that her le indicated that Nurse # Resident #1 or ask Re NA #1 indicated that s had informed Nurse # #1 from shower chair #1 manually. NA #1 s not fall during transfer could not recall if Res	sfer and Resident #1 was in balized that her leg was ne. NA #1 indicated that #1 that Resident #1 eg was hurting. NA #1 #1 did not go to assess esident #1 about the pain. she could not recall if she #1 she transferred Resident to bed, by lifting Resident tated that Resident #1 did r. NA #1 further stated, she ident #1 hit her leg or foot unsfer. NA #1 revealed she						

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If continuation sheet Page 15 of 32

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345381	B. WING				C / 17/2025
NAME OF PI	ROVIDER OR SUPPLIER	L	I	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VILLAGE	CARE OF KING				440 INGRAM ROAD KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	transfer. Written statement from was reviewed. Nurse reported to me that R receiving care but wa administering medica Resident #1 if she wa heard that Resident # being repositioned. R fine. I asked Resident pain scale, and she re aware that Resident # more importantly tran that time, as that was aide." An interview was con 01/09/25 at 12:11 am 10/22/24 NA #1 repor Resident #1 a showed was hurting. Nurse #1 to Resident #1's room pain, for which Reside indicated he did not a he "did not see any re further", when Reside not in pain. Nurse #1 ask Resident #1 what not recall if he reporte about Resident #1's con Review of progress n pm, written by Nurse stated to nurse that th	chair and the bed during m Nurse #1, dated 10/25/24, #1 stated "On 10/22/24 NA esident #1 moaned while s now okay. Upon tion to Resident #1, I asked is in pain/discomfort as I had #1 expressed a groan upon esident #1 stated she was t #1 for a number on 1-10 eported none. I was not #1 had been transferred and sferred inappropriately at not reported to me by the ducted with Nurse #1 on . Nurse #1 indicated that on ted that while giving r, Resident #1 stated her leg 1 further stated that he went n and asked if she was in ent #1 stated "no". Nurse #1 ussess Resident #1 because eason to do anything ent #1 had stated she was also revealed that he did not t happened. Nurse #1 could ed to the oncoming nurse complaint of pain. ote dated 10/22/24 at 11:31 #2, indicated that "patient	F	684			
	got caught in the whe	elchair and the bed. She g was hurting and wanted					

Facility ID: 923523

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/10/2025 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_		C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	• • •	
				440 INGRAM ROAD			
VILLAGE	CARE OF KING			KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 16 which nurse did. No bruising	F 684				
		Will have medical doctor					
	confirmed she worked pm to 11:00 pm and w #1. Nurse #2 indicate her that when the NA putting her to bed Res caught in the wheelch right leg was hurting. incident to the admini- have a way of notifyin she put Resident #1's director's book for "the day (10/23/24). Nurse assess Resident #1 a bruising or swelling. N which leg she assess she had written in the Review of the medicat	25 at 2:44 pm. Nurse #2 d on 10/22/24 between 3:00 was assigned to Resident d Resident #1 reported to that gave her a shower was sident #1's right leg got hair and the bed and her Nurse #2 did not report the stration because she did not ig them. Nurse #2 stated					
	10/23/24 at 3:04 am in nurse to the room, res right leg. Resident #1 minutes prior. Applied in reach. Bed in lowes monitor."	written by Nurse #3 on ndicated that "NA called this sident complained of pain to had taken Tramadol 30 l ice and elevated. Call light st position. Will continue to de to reach Nurse #3 for an cessful.					
	Review of progress ne	ote dated 10/23/24 at 4:04					

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/10/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING				(01/	C 17/2025
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE,		01/	17/2023
10 112 01 11					40 INGRAM ROAD	2		
VILLAGE	CARE OF KING				(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 684	 pm, written by Nurse #1 has no complaints continue to monitor." include an assessment A telephone interview conducted on 01/09/2 indicated that she wort to 11:00 pm and recain on 10/23/24, that Resident #1 if she wat #1 stated she felt predit that she did not assess the provider. Nurse #4 state assess Resident #1 le had reported that she did oncoming nurse about hurting. Physician order initiate adhesive 5% patch, a leg for pain with first of 10/24/24. A progress note dated written by Nurse #5 remed (medication) pass medication for lidocait asked Resident #1 with she is now needing the she way that the she way the way th	#4, indicated that "Resident of pain at this time, will The progress noted did not int of Resident #1's right leg. with Nurse #4 was 25 at 12:29 pm. Nurse #4 rked 10/23/24 from 7:00 am led that an NA notified her ident #1's ankle was ted that she went in to ask is having pain, and Resident ty good. Nurse #4 indicated is the leg and did not notify 44 indicated that she did not eg because, Resident #1 felt good. Nurse #4 not recall reporting to the it Resident #1's ankle ed 10/23/24 for Lidocaine pplied once a day to right dose administered on d 10/24/24 at 10:41 am evealed that "during morning	F	684				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345381	B. WING				C / 17/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
VILLAGE	CARE OF KING				440 INGRAM ROAD KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Author removed cover discolored. Author as and is able to do so s present. Nurse Practi for x-ray to site. Power aware. Resident #1 m elevated as tolerated Resident #1 stated th reach." A phone interview wit on 1/9/25 at 1:45 pm. 10/24/24 she worked Nurse #5 indicated th informed her she was that it was not normal of pain especially be scheduled pain medic stated that she asked hurting her, even with scheduled pain medic that Resident #1 state hurting. Nurse #5 indi assessed Resident # swollen and discolore she then notified the x-ray's to be done. On 10/24/24 at 10:41 x-ray 2 view" was obt results received on 10 revealed "acute appe fracture."	r, right ankle noted, swollen, ked resident to wiggle toes lightly. Pedal pulses tioner (NP) made aware, ok er of Attorney (POA) made hade aware of order. Foot and cold compress applied. at felt good. Call bell within h Nurse #5 was conducted Nurse #5 indicated that on from 7:00 am to 3:00 pm. at on 10/24/24, Resident #1 in pain. Nurse #5 revealed for Resident #1 to complain cause she was already on cation. Nurse #5 further Resident #1 what was ther having received cation. Nurse #5 indicated ed that her right leg was	F	684			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345381	B. WING				C / 17/2025
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				4	440 INGRAM ROAD		
VILLAGE	CARE OF KING			۲	KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 684	hospital however she orthopedic referral. As boot to be placed and thankful for pain medi Tuesday (10/22/24) h being transferred and on/off since but that it X 3. Boot applied to ri Plan for fracture of tib (hydrocodone-acetarr (mg) give 1 tablet by n needed. Continue sch referral and continue until further recomme Multiple attempts mad interview were unsuch A physician order date hydrocodone-acetarri give 1 tablet by mouth Resident #1. Review of Resident # dated 10/29/24 revea distal tibia over fractur to palpation distal fibu ankle range of motion eversion" Diagnosis: I tibia fracture. Recomm non-weight bearing to continue fracture boot anti-inflammatory drug bone healing."	e. Patient is refusing the is okay with a stat sked physical therapy for I it is present. Patient is ications. Resident stated on er leg got caught when her leg has been hurting was an accident. Oriented ight leg. Assessment and ia and fibula: Norco ninophen) 5/325 milligrams mouth every 6 hours as neduled tramadol, start ortho wearing boot to right leg ndations from ortho." de to reach NP for an cessful. ed 10/24/24 prescribed inophen (Norco) 5/325mg, n every six hours for 1's orthopedic consultation led "tender to palpitation re site on right. Mildly tender ula, mild swelling. Gentle h. Pain with inversion and nondisplaced right distal mendations to include o right lower extremity, t. Avoid non-steroidal gs (NSAIDs) as they delay	F	684			
	conducted on 01/09/2	jional Nurse Consultant was 25 at 2:18 pm. The Regional icated that Nurse #5 was the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345381	B. WING				C / 17/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				4	440 INGRAM ROAD		
VILLAGE	CARE OF KING			۲	KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 684	first nurse to notify the Nursing (DON) and he Resident #1 had x-ray a right tibia fracture. T Consultant stated at t questioned and it was had an incident during 10/22/24. Regional Ni stated per Resident #1' wheelchair and reside Regional Nurse Cons during facility investig Nurse #5 was the only Resident #1, and this The Regional Nurse C Resident #1, and this The Regional Nurse C Resident #1 was not a 10/23/24 by a nurse. revealed that the Reg expected that nurses assessment for each On 1/9/25 at 11:00 an interviewed about Res Director indicated tha #1 at the time of the fin NP's assessment that Medical Director state the Resident #1 comp 10/22/24 but was awa made on 10/24/24. T indicated that he wou assess any resident w condition.	e previous Director of erself on 10/24/24 that y results indicating she had the Regional Nurse hat point in time staff were a revealed that Resident #1 g a transfer with NA #1 on urse Consultant further 1's interview, that during s leg got caught in ent verbalized pain. The ultant also indicated that ation it was discovered y nurse who assessed did not occur until 10/24/24. Consultant indicated that assessed on 10/22/24 or The interview further ional Nurse Consultant would document resident change of condition. In the Medical Director was sident #1. The Medical the did not assess Resident racture but had reviewed the t was done on 10/25/24. The ed he was not notified about blaints of right leg pain on are that notification was he Medical Director Id have expected staff to who had a change of	F	684			

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			0.00		OMB NO. 0938-0
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
			A. BUILDING	·	с
		345381	B. WING		01/17/2025
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01112020
				440 INGRAM ROAD	
VILLAGE	CARE OF KING			KING, NC 27021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETI
F 684	Continued From page		F 68	4	
	condition.	s residents with a change of			o /= /o =
F 689 SS=G	Free of Accident Haz CFR(s): 483.25(d)(1)	ards/Supervision/Devices (2)	F 68	9	2/7/25
	§483.25(d) Accidents				
	The facility must ensu				
		sident environment remains azards as is possible; and			
		esident receives adequate stance devices to prevent			
	This REQUIREMENT	「 is not met as evidenced			
	Based on record rev	iew, and resident and staff		F689	
		failed to provide care in a		Step 1	
		3 residents reviewed for		Resident remains in the facility. She	
		nt accidents (Resident #1). It #1 was lifted manually by		transfers with the mechanical lift and longer having pain related to the fract	
		A) #1 from the shower chair		Step 2	
		Resident #1 right leg to hit the		On 1/30/25 Director of Rehabilitation	or
		ight in between the shower		designee completed an audit of the	
		using severe pain and		transfer status of all residents that res	
	swelling. An x-ray co	mpleted on 10/24/24		in the facility. Any changes in transfer	
		ing bones in the lower leg)		status was reported to the interdiscip team, and care plans were updated.	
	fracture.			Director of Nursing or designee revie	
				all resident care plans to ensure the	
	Findings included:			correct transfer status was recorded,	2
	Resident #1 was adm	nitted to the facility on		discrepancies identified were immedi corrected. An audit was completed o	
		sis that included right hand		residents with mechanical lift to revie	
		blisthesis (a condition where		accurate documentation of their trans	
	a vertebra in the spin	e slips out of place and onto		status. Any discrepancy identified wa	s
	, .	binal stenosis (narrowing of		clarified with the staff member to corr	ect
	-	occurs over time), and		the inaccurate documentation or 1:1	
	hypertension.			education was provided on using the	

Event ID: KGG611

Facility ID: 923523

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/10/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345381	B. WING		C 01/17/2025
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
VILLAGE	CARE OF KING			140 INGRAM ROAD KING, NC 27021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO
F 689	Resident #1's quarter dated 08/30/24 revea intact, with no behavi pounds. The quarter indicated Resident # limitation in range of upper extremity (sho and lower extremity (required a wheelchai assessment also indi dependent (Resident complete the activity) more helpers is requi complete the activity) chair/bed-to-chair tra to and from a bed to was unable to walk. An interview with the was conducted on 01 Regional Nurse Cons could not provide the care plan for Resident Regional Nurse Cons	rly Minimum Data Set (MDS) aled she was cognitively fors and weighed 104 y assessment further 1 had impaired functional motion to both sides of her ulder, elbow, wrist, hand) hip, knee, ankle, foot) and r for mobility. The quarterly cated Resident #1 was to does none of the effort to Or, the assistance of 2 or fired for the resident to) with transferring from nsfer (the ability to transfer a chair [or wheelchair]) and Regional Nurse Consultant 1/09/25 at 2:18 pm. The sultant indicated that she printed and updated manual at #1, because the Care Plan s were missing. The sultant provided a care plan	F 689	transfer method in the careplan. O 2/4/25 all alert and oriented reside were interviewed if they have been transferred correctly and if they have concerns about their transfer statu concerns were voiced. Step 3 On 1/30/25 the Director of Nursing designee educated all certified nur aides and licensed nurses that the responsible for reviewing the resid profile and care plan in the electro medical record prior to transferring resident, and to notify a nurse sup if they have any questions or conc about a resident transfer status. L nurses and certified nurse aides w educated on making sure their documentation of the transfer statu accurate. Any licensed nurse, cert nurse aides, and licensed therapiss did not receive this education on 1 will receive this education prior to the next shift. All new hired licensed nurse therapist will receive this education	nts ve any s. No or rse y are ent nic g a ervisor erns icensed rere also us is ified t who /30/25 their urses,
	incident on 10/22/24. Interview with the Re conducted on 01/10/2 Rehabilitation Directo not walk or bear any prior to the incident th Rehabilitation Directo #1's last transfer stat department, indicated as "maximum assista	habilitation Director was 25 at 10:29 am. The or stated Resident #1 could weight to her extremities		orientation. All agency staff will red this education prior to taking an assignment. The resident profile / plan will be updated with changes transfer status by a member of the team. Mechanical lift transfer documentation will be reviewed du clinical morning meeting. Step 4 Beginning the week of 2/3/25 the I of Nursing or designee will audit 5 resident records to ensure the corn transfer status is noted on the care	care in IDT iring Director

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		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 02/10/2025 DRM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345381	B. WING		_	C 01/17/2025
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, ST		
	CARE OF KING			440 INGRAM ROAD		
VILLAGE				KING, NC 27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	was non weight beari transferred using a sl that her lower extrem she could not stand." noted that therapy do residents manually. T added that if a reside they recommend that mechanical lift. The F indicated that as far a was always maximum persons using a slidin to 10/24/24. The Point of Care His appliances or assistiv transferring?" dated 1 reviewed. The report documented on 10/02 manually." A telephone interview on 01/09/25 at 2:39 p had cared for Reside needed extensive assi did not recall Resider transfers prior to her The Point of Care His bath?" dated 10/01/2 The report indicated to 10/22/24 at 11:57 am received a shower.	rector indicated Resident #1 ing and was supposed to be iding board due to the fact ities were contracted, and The Rehabilitation Director bes not instruct any staff to lift The Rehabilitation Director int is not able to bear weight, it staff use sliding board or Rehabilitation Director as she knew, Resident #1 in assistance of one to two ing board for transfers, prior story report for "What ve devices were used for 10/01/24 -10/31/24 was indicated that NA #3 2/24 at 4:40 pm "lifted v was conducted with NA #3 bm. NA #3 indicated that she int #1 and that Resident #1 sistance with transfers and int #1 using mechanical lift for incident on 10/22/24. story report for "Type of 4 -10/31/24 was reviewed. that NA #2 documented on in that Resident #1 had story report for "How did ated 10/01/24 -10/31/24 was indicated that NA #2	F 6	and that staff are do transfer status in the record. The Director Designee will obser per week to ensure the resident correct care plan and that so technique during the Director of Nursing interview 5 resident they are being trans and that they have their transfer status for 12 weeks. Results of these au before the Quality A Performance Comm monitoring or modif monthly for 3 month Assurance and performance Comm	rve 5 staff members they are transferring ty according to the staff are using proper e transfer. The or designee will ts per week to ensure sferred appropriately no concerns about a. Audits will continue dits will be brought Assurance and nittee for any additional fication of this plan hs. The Quality formance Improvement dify this plan to ensure in compliance. sing will be lementation of the	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/10/2025 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_		C 17/2025
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	• • •	
			4	40 INGRAM ROAD			
VILLAGE	CARE OF KING			(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page Resident #1 was "tota The Point of Care His provided for transferri -10/31/24 was review NA #2 documented on Resident #1 required The Point of Care His appliances or assistiv transferring?" dated 1 reviewed. The report documented on 10/22 "transfer aid." An interview was cone 01/08/25 at 1:15 pm. she recalled when he #1 indicated that NA # her a shower and had room. Resident #1 indicated that NA # her asfer her back to b that NA #1 transferred	e 24 al dependence." tory report for "Staff support ng?" dated 10/01/24 ed. The report indicated that n 10/22/24 at 11:57 am that "1-person physical assist." tory report for "What e devices were used for 0/01/24 -10/31/24 was indicated that NA #2	F 689				
	lifting her off the show Resident #1 indicated walk. Resident #1 ind	ver chair onto the bed. I that she could not stand or icated that NA #1 did not for the transfer, and no staff,					
	indicated that majority manually and a coupl sliding board to transf indicated that sometir member lifting her ma two staff lifting her ma used a mechanical lift	at incident. Resident #1 / of the time staff lifted her e of times staff used a fer her. Resident #1 nes it would be one staff anually during a transfer or anually, but no one ever t to transfer her. Resident #1 IA #1 lifted her manually					

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	OF DEFICIENCIES	MEDICAID SERVICES					10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTR			MPLETED
			A. DOILDIN				С
		345381	B. WING			0	1/17/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET AD	DDRESS, CITY, STATE, ZIP CODE		
				440 INGRA	AM ROAD		
VILLAGE	CARE OF KING			KING, NC	27021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETIO DATE
					DEFICIENCY)		
F 689	Continued From page	e 25	F 6	89			
		r to the bed, Resident #1's		10.5			
		and got stuck between the					
		d. Resident #1 indicated that					
	she informed NA #1 that she was hurting. Resident #1 indicated that NA #1 proceeded with						
		uring the transfer, even after					
		r leg was in severe pain of a					
		he least pain and 10 being					
	, , ,						
	the worst pain imaginable). Resident #1 indicated NA #1 completed the transfer and placed her in						
	bed and she did not f						
	Resident #1 indicated						
		r during the transfer from the					
		ed. Resident #1 indicated					
		to assess her after she had					
		at her leg was in severe pain.					
		that days later, the pain got					
		I not bear it. Resident #1					
	, ,	ormed another NA (Resident					
		e) about her pain getting					
		ndicated at that time, Nurse					
		her and that Nurse #5 was					
	the only nurse who as						
		that her pain was 10/10.					
		that Nurse #5 notified the					
		d an x-ray that revealed she					
	-	at #1 indicated that she					
		ospital and opted to be seen					
		tor. Resident #1 indicated					
		v orders for additional pain					
		vere pain in her right leg.					
		that facility staff initiated					
		ft for transfer only after x-ray					
		ad a fracture to her right leg.					
	Written statement fro	m NA #1, with no date					
		ved. The statement stated, "I					
	INA #1 gave Resident	#1 a shower and					

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	S FOR MEDICARE &				OMB NO. 0938	<u>3-03</u>			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y			
D FLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	i					
			B MINIO		С				
		345381	B. WING		01/17/202	25			
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE				
VILLAGE CARE OF KING				440 INGRAM ROAD					
				KING, NC 27021					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMP IE APPROPRIATE DA	X5) PLETIOI ATE			
F 689	Continued From page	2 26	F 68	9					
		d Resident #1 said she hurt	1 00	5					
		NA#1 that she (Resident#1)							
		rry. Resident #1 was fine,							
	and NA#1 did report i	,							
	A telephone interview was conducted with NA #1 on 01/10/25 at 9:08 am. NA #1 indicated that she								
		to 3:00 pm on 10/22/24 and							
	•	ident #1. NA #1 stated on							
		1 had a shower scheduled.							
		Resident #1 was in bed and							
		rred from the bed to the stated that she asked NA #2							
		ne transfer. NA #1 indicated							
	-	the shower chair so that							
		transferred. NA #1 revealed							
		s holding onto the shower							
		lent #1 manually because							
		able to put her feet on the							
		Resident #1's legs) were							
		nfirmed that Resident #1's							
		e floor, while she lifted her							
		d onto the shower chair. NA							
	-	t #1 was not able to bear her							
	own weight on both lo	ower extremities and							
	Resident #1 was not	able to walk. NA #1 stated							
	that there was no "en	nergency" situation occurring							
		ired for her to lift Resident							
	-	t she was just transferring							
		plan. NA #1 indicated that							
		ave any concerns during the							
		ted, after she completed the							
		sident #1 back to her room,							
		bed at around 11:00 am.							
		during this transfer (from							
	opower opair to had)	and did not have any other							
		she did not have any other							
	staff to assist. NA #1	-							

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	-	D HUMAN SERVICES				FORM	02/10/2025 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	LETED
		345381	B. WING		_	(01/ [,]	C 17/2025
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE	01/	11/2020
			4	40 INGRAM ROAD			
VILLAGE	CARE OF KING		к	(ING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	she placed Resident # that Resident #1 did r #1 further stated, she #1 hit her leg or foot of NA #1 revealed she d foot got stuck between bed during transfer. N completion of the tran bed, Resident #1 verth hurting but she was fin she reported to Nurse complained that her le indicated that Nurse # Resident #1 or ask Re NA #1 indicated that a worked again from 7:0 10/24/24 and provided #1 indicated that Regi informed her that she "breaking Resident #1 transferring her using #1 indicated that Residen plan to transfer Resider mechanical lift. NA #1 indicated that Resider assistance of one per indicated that no Nurse #5 that Resider mechanical lift. NA #1 looked for the care pla the nursing station, th missing. NA #1 indica had a care plan to use all staff lifted Resider transfers.	loor. NA #1 indicated that #1 on the bed. NA #1 stated not fall during transfer. NA could not recall if Resident on anything during transfer. id not recall if Resident #1's in the shower chair and the IA #1 indicated that after sfer and Resident #1 was in palized that her leg was ne. NA #1 indicated that e #1 that Resident #1 eg was hurting. NA #1 ed di not go to assess esident #1 about the pain. after this day (10/22/24), she D0 am to about 3:00 pm on d care to Resident #1. NA ional Nurse Consultant would be suspended for I's leg" due to not a total mechanical lift. NA dent #1 did not have a care ent #1 using a total indicated that the care plan nt #1 required extensive son to transfer. NA #1 4/24, she was informed by nt #1 was supposed to be a indicated that when she an books with Nurse #5 at e care plan books were ted that Resident #1 never e a mechanical lift and that t #1 manually during all	F 689				
		n NA#2, dated 10/24/24 indicated, "On 10/24/24 I					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/10/2025 MAPPROVED). 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		345381	B. WING			_		C 17/2025	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	• •		
VILLAGE	CARE OF KING				40 INGRAM ROAD ING, NC 27021				
		ATEMENT OF DEFICIENCIES	10					(XE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 689	#1 and informed me t broken. 10/22/24 Res witnessed another tra chair. NA pick Reside	28 acility on behalf of Resident hat Resident #1 leg was ident #1 shower day, I nsfer Resident #1 to shower nt #1 up and put Resident so, on 10/24/24 facility	F	689					
	informed that Resider only witness the trans chair. I did not make a #1."	nt #1 is a mechanical lift. I ifer from bed to shower any contact with Resident							
	Multiple attempts mad interview were unsuce	de to reach NA #2 for an cessful.							
	written by Nurse #5 re medication pass auth lidocaine patch to righ Resident #1 what hap now needing that. Re (10/22/24) her leg got transferred and her le since. Author asked F has been, and Reside but once she got her better and was able to is having trouble flexin Author removed cove discolored. Author asl and is able to do so s present. Nurse Practif for x-ray to site. Powe aware. Resident #1 m elevated as tolerated Resident #1 stated the reach."	ppened to her leg that she is sident #1 stated on Tuesday caught when being g has been hurting on/off Resident #1 how her pain ent stated it hurt last night pain medication she felt o rest and this morning she ng her toes to right leg. r, right ankle noted, swollen, ked resident to wiggle toes lightly. Pedal pulses tioner (NP) made aware, ok er of Attorney (POA) made nade aware of order. Foot and cold compress applied. at felt good. Call bell within							
		am, order for "right ankle ained by Nurse #5. X-ray							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/10/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345381	B. WING		_		C 17/2025
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
VILLAGE	CARE OF KING			40 INGRAM ROAD KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	revealed "acute appear fracture." A progress note dated indicated "86-year-old seen today for right til yesterday about incre- right ankle and x-ray of fracture. Patient is ref she is okay with a sta physical therapy for b present. Patient is that Resident stated on Tu got caught when bein has been hurting on/c accident. Oriented X 3 Assessment and Plan fibula: Norco (hydroco 5/325 milligrams (mg) every 6 hours as need tramadol, start ortho r wearing boot to right I recommendations from Multiple attempts were interview were unsuced Review of Medication (MAR) for 10/01/24 - MAR indicated new o hydrocodone-acetami give 1 table by mouth order initiated on 10/2 5% patch, applied ond with first dose administ Review of Resident #	0/24/24 at 3:46 pm that aring distal tibia/fibula d 10/25/24 written by the NP I female patient is being bia/fib fracture. Contacted ased swelling and pain to was ordered demonstrating using the hospital however t orthopedic referral. Asked oot to be placed and it is unkful for pain medications. uesday (10/22/24) her leg g transferred and her leg off since but that it was an 3. Boot applied to right leg. of or fracture of tibia and bodone-acetaminophen) o give 1 tablet by mouth ded. Continue scheduled eferral and continue eg until further m ortho." e made to reach NP for an cessful. Administration Record 10/31/24 was reviewed. rder initiated on 10/24/24 of inophen (Norco) 5/325mg, every six hours pain. New 23/24 for Lidocaine adhesive be a day to right leg for pain, stered on 10/24/24.	F 689				
		led "tender to palpitation					

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CENTERS FOR MEDICARE & M	IEDICAID SERVICES				M APPROVED D. 0938-0391	
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345381	B. WING _			C / 17/2025	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
VILLAGE CARE OF KING			440 INGRAM ROAD			
VILLAGE CARE OF RING			KING, NC 27021			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
to palpation distal fibul ankle range of motion. eversion" Diagnosis: n tibia fracture. Recomm non-weight bearing to continue fracture boot. anti-inflammatory drug bone healing." Interview with MDS Nu 01/09/25 at 12:35 pm. that she did not recall a #1's incident with trans reviewed by the interdi Nurse #1 indicated tha walk or bear her own v An interview with Regi conducted on 01/09/25 Nurse Consultant indic first nurse to notify the Nursing (DON) and he Resident #1 had x-ray a right tibia fracture. TI Consultant stated at th questioned and it was had an incident during 10/22/24. The Regiona indicated that NA #1 tr a shower chair to the b Regional Nurse Consu Resident #1 was supp using a mechanical lift stand. Regional Nurse #1 stated that she tran "stand and pivot" techr	e site on right. Mildly tender la, mild swelling. Gentle . Pain with inversion and condisplaced right distal nendations to include right lower extremity, . Avoid non-steroidal gs (NSAIDs) as they delay urse #1 was conducted on MDS Nurse #1 indicated anything about Resident sfers being discussed or isciplinary team. MDS at Resident #1 could not weight. onal Nurse Consultant was 5 at 2:18 pm. The Regional cated that Nurse #5 was the previous Director of erself on 10/24/24 that results indicating she had he Regional Nurse nat point in time staff were revealed that Resident #1 a transfer with NA #1 on al Nurse Consultant further ansferred Resident #1 from bed with NA #2. The ultant further stated osed to be transferred to be consultant indicated NA asferred Resident #1 using	F	589			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 02/10/2025 APPROVED . 0938-0391
		E CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED		
		345381	B. WING		_	(01/	; 17/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	• 11	
VILLAGE	CARE OF KING			440 INGRAM ROAD			
				KING, NC 27021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	while in room, transfe shower chair to bed. Consultant stated during indicated that during to caught in the wheelch verbalized pain. Regin indicated that NA #1 of that there was an issu- interviewed on 10/24/ An interview was con Administrator on 01/1	rred Resident #1 from The Regional Nurse ring interview Resident #1 the transfer her leg got hair and Resident #1 onal Nurse Consultant did not verbalize or report ue with the transfer when '24. ducted with the 0/25 at 11:30 am. The ed that all residents should	F 689				

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