STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to complete a significant change in status assessment for 1 of 1 sampled residents (Resident # 48). The findings included: Resident # 48 was admitted to the facility on 11/18/2016 with diagnoses that included muscle weakness, End Stage Renal Disease (ESRD), type 2 diabetes mellitus (DM2), anemia, insomnia and bladder cancer. The admission Minimum Data Set (MDS) dated 11/25/2016, was coded to indicate that Resident # 48 had moderate cognitive impairment and that Resident # 48 required limited assist of 1 staff for bed mobility, dressing and personal hygiene. Resident # 48 was also coded that extensive assist of 1 staff was needed for transfers, toilet use and bathing. Resident # 48 was coded as being independent for locomotion on the unit and	F 274	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F274 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: A significant change in status was scheduled for resident #48 with an	4/6/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/30/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 1 revealed that Resident # 48 and direct care staff believed that Resident # 48 was capable of increased independence in at least some activities of daily living (ADLs). Resident # 48 was coded as being at risk for developing pressure ulcers and had a pressure reducing device on his bed and received 7 days of antidepressant medication and 3 days of antibiotic medication. Resident # 48 received intravenous (IV) medications during the previous 14 days. The quarterly MDS dated 01/27/2017, revealed that Resident # 48 was moderately cognitively impaired and required supervision and 1 staff assist with bed mobility, dressing, toileting and personal hygiene. Resident # 48 was coded as requiring supervision with set up for transfers, locomotion on and off the unit and bathing. The MDS was coded that Resident # 48 had a pressure reducing device on his bed and that ointments or medications had been applied to an area of his body but not to the feet and was at risk for developing pressure ulcers. Resident # 48 did not receive antidepressant medication and received 7 days of anticoagulant medication and did not receive IV medication during the review period. An interview conducted with the MDS coordinator on 03/09/2017 at 3:02 PM revealed that Resident # 48 should have had a significant change in status MDS completed and that it would be scheduled immediately to accurately code the status of Resident # 48 because of ADL coding changes on the quarterly MDS. The Director of Nurses (DON) was interviewed on 03/09/2017 at 4:55 PM and revealed that it was expected that all care givers should be	F 274	ARD of 3/10/17. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: The MDS Staff and Inter-Disciplinary Team (IDT) will complete an audit by March 31st, 2017 of all current residents with an MDS completed within the last 30 days using the MDS assessment warnings report with noted improvement or decline in condition to assess need for a significant change assessment. A significant change MDS will be scheduled if the IDT determined a change occurred in the resident□s status. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Regional Data Analyst and Verification Specialist educated the MDSC on RAI Manual requirements for a significant change in status-decline or improvement on March 17, 2017. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The IDT will review the 72 hour shift report three times a week to determine if a resident□s change in status requires the scheduling of a SC MDS and revision of the care plan. The MDSC or designee will audit 5 residents with a change in condition from the 72 hour report and MDS assessment warning report to determine if a SC MDS is required along with the revision of the care plan. This audit monitoring will occur weekly x 4 weeks, then 2 weekly for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 2 communicating resident care needs with all other care givers so that decisions could be made to determine the need for a significant change MDS and if a change in status was determined, that a significant change MDS be completed to reflect the status of the residents.	F 274	months, and then monthly for 4 months. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC or IDT. Results of the audits will be presented to the quarterly Quality Assurance Committee for review and recommendation.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The	F 280		4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 3 planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 4 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and resident interview and observation, the facility failed to update the care plan and add interventions to treat and prevent a burn on the right buttock for 1 of 1 residents reviewed for care plan updates. (Resident # 48). Findings included: Resident # 48 was admitted to the facility on 11/18/2016 with diagnoses that included muscle weakness, End Stage Renal Disease (ESRD), type 2 diabetes mellitus (DM2), anemia, insomnia and bladder cancer. A quarterly Minimum Data Set (MDS) dated 01/27/2017, revealed that Resident # 48 was moderately cognitively impaired and required supervision and 1 staff assist with bed mobility, dressing, toileting and personal hygiene. Resident # 48 was coded as requiring supervision with set up for transfers, locomotion on and off the unit and bathing. The MDS was coded that Resident # 48 had a pressure reducing device on his bed and that ointments or medications had been applied to an area of his body but not to the feet and was at risk for developing pressure ulcers.	F 280	F280 How corrective action will be accomplished for each resident found to have been affected by the deficient practice. Resident #48 □ Care plan was updated on March 8, 2017 to include intervention for burn prevention. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. An audit will be completed by the Director of Nursing or her designee to identify current residents with changes of condition and, if appropriate, ensure new interventions are in place on each identified individual□s care plan by March 31, 2017. Measures to be put in place or systemic changes made to ensure practice will not re-occur. The Director of Nursing or her designee will conduct an audit of all residents, if any, with changes of condition weekly x 1 month and then 5 change of condition care plans monthly x 2 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur. The results of these audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 Resident # 48 did not receive antidepressant medication and received 7 days of anticoagulant medication and did not receive IV medication during the review period. A review of the care plans for Resident # 48 revealed that the care plans revised on 11/21/2016 and 11/23/2016 included that resident # 48 had a potential for skin impairment and a goal that there would be no evidence of skin impairment through the next review with interventions that included lotion to dry skin, moisture barrier cream as needed to protect skin and to perform weekly skin checks. The weekly assessment dated 01/21/2017 revealed that Resident # 48 had a rash over his body and multiple scabs from scratching. A physician (MD) order dated 02/20/2017 was to apply hydrocortisone lotion 2.5% to affected skin topically every day and every evening for skin care due to scratching. A skilled nurse note dated 02/22/2017 at 2:37 PM revealed that Resident # 48 had reported to the nurse at 1:30 PM that he, Resident # 48, had a coffee burn on his bottom and Resident # 48 also revealed that the burn had occurred a couple of days ago and no one had been told except for his grandson that had been visiting at that time. Resident # 48 stated that he had not told anyone else until this time because the burn had just started bothering him. The nurse revealed that the MD was notified and that treatment orders had been received from the MD. The nurse completed a change in condition form that included vital signs within normal limits for Resident # 48 and the burn was assessed and	F 280	will be reviewed at the weekly Risk Quality Assurance Meeting for three months. The results of these audits will be reported to the quarterly QA&A committee for a period of two quarters for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6	F 280		

measured 9.0 centimeters (cm) in length by 2.0 cm in width (9.0 cm x 2.0 cm). The nurse revealed that she had left a voice mail for the daughter of Resident # 48 to call the facility and that a complete report was given to the nurse on the next shift.

An MD order note dated 02/22/2017 was to cleanse the coffee burn site of the right buttock of Resident # 48 with wound cleanser, apply silvadene cream 1% to the right buttock burn, cover with allevyn dressing and change the dressing daily until the burn was healed.

A facility incident report dated 03/02/2017 at 4: 12 PM revealed that Resident # 48 reported to nurse on 02/22/2017 that he had received a burn on his right buttock from spilling his coffee and the MD and the daughter of Resident # 48 had been made aware on 02/22/2017.

A review of a weekly wound round form completed on 03/04/2017 revealed that the treatment continued to the right buttock of Resident # 48.

A review of the treatment administration record (TAR) and cumulative MD orders dated 03/2017 revealed that the MD ordered to cleanse the coffee burn of the right buttock with wound cleanser, apply silvadene cream and cover with an allevyn dressing daily until the burn is healed.

An interview with the Dietary Manager on 03/08/2017 at 12:15 PM revealed that coffee is prepared in the kitchen, transferred into Cambro insulated containers for delivery to each nursing unit and the lobby. The dietary manager revealed the nursing assistants (NAs) were responsible for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7	F 280		

pouring the coffee for each resident when meal trays were delivered. The internal temperature of the coffee in the kitchen was taken and registered 183 degrees Fahrenheit. The Dietary Manager stated he was not aware of any concerns related to the coffee temperature or any resident being burned with the coffee.

A follow up interview conducted with the Dietary Manager on 03/09/2017 at 8:40 AM revealed that Resident # 48 was very independent and drank a lot of coffee daily. The Dietary manager revealed that Resident # 48 liked to get his coffee from the lobby coffee urn and that on an unknown date it was agreed that Resident # 48 would carry his coffee in a closed thermos which would be filled by facility staff. The dietary manager could not confirm that Resident # 48 filled the thermos independently at times. The Dietary manager revealed that he had not been made aware that Resident # 48 had received a coffee burn until 2 days ago and that the Dietary Manager had immediately purchased 2 types of covered coffee cups for Resident # 48 to try. The Dietary Manager revealed that the use of the covered thermos and covered mugs were not his responsibility to care plan and that the nurses were responsible for the care plan updates. The Dietary Manager could not explain how the nurses were given information to update resident care plans.

An interview conducted with resident # 48 on 03/09/2017 at 9:02 AM interview revealed that Resident # 48 used a thermos to carry his coffee behind his back on the seat of his wheel chair and that the thermos top must have been loose and when Resident # 48 moved in his wheel chair, the coffee spilled on to his chair seat and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8	F 280		

soaked his pants on the right side. Resident # 48 revealed that he did not report it to the nurse for a few days until his "bottom" started to bother him. Resident # 48 also revealed that he had been recently received 2 coffee mugs with lids on them to try and that the new mugs were working "fine." Resident # 48 also revealed that the staff filled his thermos for him and that he preferred the coffee from the front lobby. Resident # 48 agreed to allow observation of the right buttock wound treatment before he left for hemodialysis. Resident # 48 stated that he had covered mugs to use now to drink coffee from, but that he could not confirm that facility staff always filled the covered thermos for him.

On 03/09/2017 at 9:49 AM an observation was made of the burn treatment for Resident # 48 performed by nurse # 1. Resident # 48 was assisted to the restroom via his wheel chair so he would be able to stand up during care and able to hold on to the grab bars for safety. The right buttock dressing dated 03/08/2017 was removed. No drainage or odor was observed. Resident # 48 denied any pain or discomfort. Nurse #1 cleansed the right buttock burn with dermal wound cleanser and obtained measurements of 6 cm x 2 cm. The skin was intact and was pink at the edges and red and shiny in the center. No open areas were observed. Resident # 48 stated that the burn felt better and was only sore if he sat in the chair for long periods of time. Nurse # 1 stated that the burn was first degree and was healing without complications.

An interview conducted with the MDS coordinator on 03/09/2017 at 3:02 PM revealed that the use of a covered thermos, covered coffee cups or that Resident # 48 had received a coffee burn had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 9 been related to him until 03/08/2017 and that he was going to update the care plans for Resident # 48 on 03/09/2017 as he needed to confirm from other facility staff the current interventions implemented to update the care plan of Resident # 48 and to be certain the care plans reflected current care interventions for Resident # 48. The MDS coordinator revealed that all licensed nurses and members if the interdisciplinary care plan team were responsible for care plan updating. On 03/09/2017 at 4:45 PM with the Director of Nurses (DON) revealed that the expectation was that all resident care plans were to be updated as resident care changed by licensed nurses and members of the care plan team so that each care giver had the most current and accurate information when providing resident care.	F 280		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed	F 356		4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 10 vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed accurately report the resident census and staffing figures on the Staff Posting for 4 of 4 survey days on all 3 shifts, failed to exclude the residents residing in non Skilled Nursing Facility level of care beds from the census total, and failed to exclude the staff time allocated to those residents from the staff posting figures for the	F 356	F356 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: No specific resident was affected by deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 11 designated Skilled Nursing Facility level of care beds. The findings included: Review of the Daily Nurse Staffing Summary (Staff Posting) for 3/6/17, 7:00 AM - 3:00 PM revealed the resident census was listed as 91 residents at the start of the shift. It also indicated there were 4 Licensed Practical Nurses and 6 Certified Nurse Aids NA) providing care to all 91 residents. During the initial tour 4 Licensed Practical Nurses and 6 NA ' s were located Review of the Patient List Report for 3/6/17 printed at 11:01 AM revealed a list with 92 names on it. Interview with the Regional Nurse Consultant on 3/6/17 at 11:30 AM revealed that there had been one discharge since the Patient List Report had been updated. In addition she added that the residents in Assisted Living level of care beds had not been excluded from the list. She crossed the one discharged resident off the list as well as 8 other residents that were not residing in the facility ' s designated SNF bed. She then confirmed the facility resident census for residents in SNF care was 83. Review of the Daily Nurse Staffing Summary for 3/6/217, 3:00 PM - 11:00 PM through 3/8/17, 3:00 PM - 11:00 PM revealed the census listed remained at 91 and the full complement of direct care nursing staff in the facility were included. On 3/8/17, 11:00 PM - 7:00 AM the census listed at the start of the shift was 92 and the listed census remained 92 through the end of the survey 3/9/17, 3:00 PM - 11:00 PM. The full complement	F 356	How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Director of Nursing and designees are to be educated by regional nurse consultant on posted nurse staffing and census. Measures to be put in place or systemic changes made to ensure practice will not re-occur: Administrator and/or Director of Nursing will conduct audit of daily nurse staffing summary for completeness weekly for 4 weeks; once every two weeks for 4 weeks and monthly for one month. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of these audits will be reviewed at Weekly Risk Quality Assurance Meeting for three months and at Quarterly Quality Assurance meeting for two meetings for further resolution if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 12 of direct care nursing staff in the facility continued to be included on the Staff Posting. Interview with the Administrator on 3/9/17 at 5:00 PM revealed that he was aware of the requirement to include only SNF residents and designated nursing staff in the staff posting figures. He acknowledged that if the Staff Positing was indicating 91 or 92 residents it was incorrect and that the staff hours for those residents that were not in SNF beds should also be excluded. He indicated he had some thoughts on how it to ensure accuracy of the Staff Posting and that he would investigate and resolve the issue.	F 356		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 13 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to ensure dishware were air dried, kitchen equipment was clean, opened food was sealed, labeled and dated and expired food was discarded. Findings Included: An observation of the kitchen on 3/6/17 at 10:55 am with the Dietary Manager revealed 17 of 17 meal trays and 16 of 20 plate covers were stacked together wet and stored on the tray line ready to be used for lunch service. A 5 pound container of cottage cheese with an expiration date of 3/3/17 was stored in the reach-in cooler. A package of sliced bologna was thawing in the reach-in cooler with no label or date. A 20 pound case of green beans was open and exposed to the air in the walk-in freezer. A bowl storage cart with food particles and stains contained clean plates and bowls. An interview on 3/6/17 at 11:15 am with Dietary Aide #1 revealed that the meal trays and plate covers should have been allowed to air dry prior to being placed on the tray line for meal service. An interview on 3/6/17 at 11:20 am with the Dietary Manager revealed that the cottage cheese with an expiration date of 3/3/17 should have been thrown away. He additionally stated that the bologna should have been labeled and dated when it was placed in the cooler for thawing and that the case of green beans should have	F 371	F371 How the corrective action will be accomplished for the resident (s) affected. On 3/6/17 and 3/8/17, plate covers found stacked wet were removed immediately and taken to be cleaned and sanitized and restored with the ability to air dry at the time of observation. On 3/6/17, meal trays found stacked wet were removed immediately and taken to be cleaned and sanitized and restored with the ability to air dry at the time of observation. On 3/6/17, the expired cottage cheese container was removed immediately and discarded at the time of observation. On 3/6/17, the unlabeled/undated bologna was removed immediately and discarded at the time of observation. On 3/6/17, the case of green beans exposed to air was immediately removed and discarded at time of observation. On 3/6/17, bowl storage cart and dishes that were stored in the soiled cart were removed immediately and taken to be cleaned and sanitized.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 14 been fully sealed. An observation of the kitchen on 3/8/17 at 11:50 am with the Dietary Manager and Cook #1 revealed 5 of 10 plate covers were stacked together wet and stored on the tray line ready to be used for lunch service. The bottom interior of the convection oven had spills and blackened food particles. The hood vents had a build- up of dust and grease. An interview on 3/8/17 at 12:00 pm with the Dietary Manager and Cook #1 revealed the convection oven and the hood vents were scheduled to be cleaned once a month or more often if needed. A review of the cleaning schedule, provided by the Dietary Manger on 3/8/17 revealed the front and top of the convection oven was scheduled to be wiped down daily and the bowl storage cart was scheduled to be cleaned weekly. The hood vents were not identified on the cleaning schedule. An interview on 3/9/17 at 3:27 pm with the Dietary Manger revealed that it was his expectation that the meal trays and plate covers were kept in drying racks to ensure they were air dried. He stated the convection oven and hood vents were scheduled to be deep cleaned monthly and the bowl storage rack was scheduled to be deep cleaned weekly. An interview on 3/9/17 at 3:50 pm with the Administrator revealed it was his expectation that dishware would not be wet nested. He stated he expected all kitchen equipment to be clean and that food should be labeled, dated, sealed and	F 371	On 3/8/17, hood vents were removed after lunch service and taken to be cleaned and sanitized and restored. On 3/8/17, the convection oven that was soiled was removed to be cleaned and sanitized after lunch service. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The department equipment cleaning schedule was updated on March 27, 2017 to include more frequent cleaning of the convection oven, hood filters and storage caddies. All Dining Services employees were in-serviced regarding proper procedures for discarding expired food items, labeling and dating items when received and opened, air-drying equipment, cleaning schedule and cleaning procedures on March 10, 2017 and again during the period March 29-30, 2017. Position job responsibilities regarding sanitation standards were reviewed with each Dining Services employee during the period march 27-31, 2017. Measures in place to ensure practices will not occur. A sanitation inspection will be conducted weekly x 4 weeks, twice-monthly x 1 month, and at least monthly thereafter to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 15 used by its expiration date.	F 371	ensure compliance with corrective actions and sanitation standards. All new hires will receive in-service education on proper procedures for discarding expired food, labeling and dating items when received and opened, air-drying equipment, cleaning schedule and cleaning procedures. Any deficient practice identified through the sanitation inspections will result in reeducation or disciplinary action as indicated. How the facility plans to monitor and ensure corrections is achieved and sustained. Findings will be reviewed at the Quarterly Quality Assurance meeting for two quarters for tracking and trending.	
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and	F 412		4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 16 (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to offer dental services to a resident on Medicaid, for 1 of 2 residents reviewed for dental services (Resident # 7). Resident #7 was admitted 5/20/12 with diagnoses including hypertension, diabetes and anxiety. Review of the Quarterly Minimum Data Set (MDS) dated 10/21/16 revealed Resident #7 was cognitively impaired, required limited assistance for personal hygiene and was on hospice. Review of the Significant Change MDS dated 11/4/16 reveled Resident #7 was cognitively impaired, required extensive assistance for personal hygiene and was no longer on hospice. No dental issues were coded on the MDS. Review of the Quarterly Minimum Data Set (MDS) dated 1/27/17 revealed Resident #7 was cognitively impaired, required extensive assistance for personal hygiene and was not on hospice. On 3/8/17 at 5:15 PM Resident #7 was observed up in her wheelchair. She appeared to have missing teeth but it was difficult to observe as she did not open her mouth very wide and got	F 412	How corrective action will be accomplished for each resident found to have been affected by the deficient practice. The facility's Discharge Planning Director contacted the family of Resident #7 on 3/10/17 with an offer of dental services. The family declined to have Resident #7 see the dentist. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. The facility's Discharge Planning Director or her designee audited all resident charts to ensure that dental services were either provided or offered during the last year. Appointments, as necessary, were made with the facility dentist during his routine monthly visit. Measures to be put in place or systemic changes made to ensure practice will not re-occur. The facility's Director of Discharge planning will have proponency for this requirement. The Director of Discharge Planning, or her designee, will review resident records during each annual or quarterly MDS assessment for compliance with this requirement, thus allowing for at least four reviews of each long-term resident each year. For the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 17 agitated with questioning. Interview with the Social Worker (SW) on 3/9/16 at 1:30 PM revealed the dentist had been at the facility in February 2017 but Resident #7 had not been seen and was not on the list for the April visit. The SW reviewed the resident ' s medical record and could not locate any documentation regarding previous dental consults, refusals or declined consent. She acknowledged the resident ' s payer source was Medicaid and that dental services should be provided. The SW then recalled that Resident #7 had previously been on Hospice Services so did not receive dental services. She acknowledged that when her hospice services were discontinued Resident #7 was not picked back up to be seen by the dentist.	F 412	period April-September 2017, the Director of Discharge Planning will maintain a log of any resident she finds to be outside the 1-year period for dental services, if any, during these quarterly or annual reviews. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur. The results of these audits will be reviewed by the Director of Discharge Planning during the weekly Risk Quality Assurance Meeting for six months. The results of these audits will be reported to the quarterly QA&A committee for a period of two quarters for review and revision as needed.	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident;	F 514		4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 18 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, medical record review and resident interview and observation the facility failed to maintain complete and accurate medical records related to documentation of pressure ulcer care for 1 of 3 residents reviewed for complete and accurate medical records for pressure ulcers (Resident # 179). The findings included: Resident # 179 was admitted to the facility on 01/27/2017 with diagnoses that included congestive heart failure (CHF), chronic kidney disease (CKD) stage 3, localized edema, muscle weakness and atrial fibrillation. Review of the admission Minimum Data Set (MDS) dated 02/03/2017 revealed that Resident # 179 was alert and oriented and required extensive assist of 2 staff for bed mobility, transfers, toilet use and bathing. Resident # 179 required extensive assist of 1 staff for dressing	F 514	F514 How corrective action will be accomplished for each resident found to have been affected by the deficient practice. Resident #179 □ Wound record, care plan, and orders were updated on March 8, 2017. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. An audit will be completed by the Director of Nursing or her designee to identify current residents with wounds to ensure wound records, care plan and treatment orders are in place by March 31, 2017. Measures to be put in place or systemic changes made to ensure practice will not re-occur. The Director of Nursing or her designee will conduct an audit of all new residents, if any, with wounds weekly x 1 month and then 5 new admissions	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 19 and personal hygiene. Resident # 179 was coded as having occasional bladder incontinence and received a therapeutic diet and was at risk for developing pressure ulcers and had no pressure ulcer at that time. The MDS was coded to reveal that Resident # 179 had a pressure reducing device on the bed. Review of the Care Area Assessments (CAAs) dated 02/03/2017 revealed that Resident # 179 needed assist with activities of daily living (ADLs), had bowel and bladder incontinence and had no skin breakdown. Resident # 179's care plans were revised on 01/30/2017 and included a care plan that Resident # 179 had the potential for skin impairment with a goal of no evidence of skin impairment through the next review. Interventions included to keep skin clean and dry, lotion dry skin, peri care with incontinence episodes, pressure reduction mattress, pressure reduction surface to the wheelchair and to perform weekly skin assessments. Review of a wound record dated 01/27/2017 revealed that Resident # 179 was admitted with a surgical wound of the right side of his neck. A weekly skin assessment dated 02/01/2017 revealed that Resident # 179 had redness of the buttocks. On 02/08/2017, a wound record dated 02/08/2017, revealed that Resident # 179 had acquired a stage 3 pressure ulcer of the sacrum which had granulation tissue and slough tissue and measured 2 centimeters (cm) in length, 1 cm in width and 0.1 cm in depth. The wound edges were red and irregular and the peri- wound tissue was red and blanchable. The current treatment plan revealed allevyn and the comment section	F 514	monthly x 2 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur. The results of these audits will be reviewed at the weekly Risk Quality Assurance Meeting for three months. The results of these audits will be reported to the quarterly QA&A committee for a period of two quarters for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 20	F 514		

revealed that Resident # 179 had a red area to his sacrum on admission and to refer to the admission assessment. The physician (MD) and family of Resident # 179 were notified on 02/08/2016.

Review of a nutrition/dietary note dated 02/09/2017 revealed that Prostat AWC 30 milliliters (ml) would be given three times a day (TID) to aid wound healing and double portions of meat for increased protein was added to meals recommended to the MD.

Review of a physician progress note dated 02/14/2017 revealed that Resident # 179 had a stage 2 sacral decubitus.

A review of a skilled nurse note dated 02/14/2017 at 7: 43 PM revealed that Resident # 179 had been seen by the MD that evening and that frequent repositioning was needed, it was okay to upgrade the mattress of Resident # 179 for the sacral decubitus if needed and to obtain a dietary consult.

A review of a weekly skin assessment dated 02/15/2017 revealed that Resident # 179's buttocks/sacrum were red and blanchable open area 3cm x 1 cm x 0.1 cm.

An MD order dated 02/16/2017 was to administer Prostat SF AWC 30 ml by mouth TID for nutrition/ wound healing.

A wound record dated 02/22/2017 revealed that Resident # 179 had an acquired pressure area of the sacrum stage 3 which had been red on admission. The tissue was observed as epithelial and measurements recorded were 2 cm x 0.5 cm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 21	F 514		

x 0.2 cm with red peri-wound tissue and irregular wound edges. The treatment plan was allevyn. The MD and resident were notified on 02/22/2017.

Review of the weekly skin assessment dated 02/22/2017 revealed that Resident # 179 had a stage 3 to the sacrum.

A nutrition/ dietary note dated 02/26/2017 at 11:48 AM was reviewed and revealed that Resident # 179 had been referred by the MD for wounds. Resident # 179 received a renal diet and consumed between 50 - 100% of meals. Resident # 179 exhibited an up- trend in weights and received a multivitamin with minerals for the stage 3 pressure ulcer.

A review of the weekly skin assessment dated 03/01/2017 revealed that Resident # 179 had a stage 3 to the sacrum and to see wound report. Weekly skin assessment dated 03/03/2017 revealed a stage 3 pressure ulcer which measured 3.8 cm x .2 cm x .2 cm. The wound record completed on 03/03/2017 revealed that Resident # 179 had an acquired pressure ulcer stage 3 of the gluteal fold with epithelial tissue with well- defined wound edges. No inflammation was present, allevyn was placed to protect and the wound was healing. The MD and family of Resident # 179 were updated on 03/03/2017. Review of a weekly skin assessment dated 03/08/2017 noted a wound to the sacrum and to see the wound report. The wound record dated 03/08/2017 revealed that Resident # 179 had an acquired stage 3 pressure ulcer of the sacrum that measured 3.8 cm x 0.2 cm x 0.2 cm. The peri-wound tissue was red; no inflammation was present and the treatment was allevyn and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 22	F 514		

wound was healing. The MD and Resident # 179 were updated.

A review of the treatment administration records (TARs) and medication administration records (MARs) on 03/08/2017 revealed that from 02/08/2017 through 03/07/2017, Resident # 179 did not have a treatment in place for the stage 3 pressure ulcer on the sacrum. On 03/08/2017, an MD order dated on 03/08/2017 was observed on the TAR of Resident # 179 for allevyn to sacrum every 3 days and as needed until healed for wound healing. The treatment was scheduled to begin on 03/09/2017.

On 03/08/2016 a review of the facility standing orders for wound care was signed by the MD on 11/08/16 and revealed the facility follow protocol for wound care which included skin tears, decubitus ulcers and surgical wounds.

The Wound Treatment Protocol Quick Reference Guide provided by the facility on 03/08/2016 revealed that a stage 3 ulcer that was shallow, red and or pink or had some slough and a moderate amount of drainage was to be cleansed with normal saline, the skin dried and then apply Skin Prep and allow to dry, apply an adhesive foam dressing (Allevyn Adhesive, Allevyn Foam, Allevyn Heel or hydrasorb) and change the dressing every three days or when strike through approaches edge of dressing.

An observation and interview with Resident # 179 on 03/08/2017 at 9:33 AM revealed Resident # 179 alert and oriented and sitting in his wheel chair in his room. A padded cushion was observed in the seat of the wheel chair. Resident # 179 was not able to recall if he had the sore on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 23	F 514		

his "bottom" when he came to the facility or not, but the nurse staff had told him that the sore was getting better and only got sore if he sat for too long in one position. Resident # 179 stated that he would allow an observation of the wound treatment, but that it was only changed every three days or so and had already been changed earlier that morning. Resident # 179 stated that if the nurse needed to change it again, he would not mind if the treatment was observed. Resident # 179 had a pressure relief mattress on his bed.

An interview was conducted on 03/08/2017 with nurse #5 at 10:06 AM. Nurse #5 revealed that Resident # 179 had a pressure ulcer on the sacrum, but he did not have a pressure ulcer when he was admitted on 01/27/2017. Nurse # 5 revealed that on 02/08/2017 a weekly wound assessment revealed that Resident # 179 had developed a stage 3 pressure ulcer on the sacrum and that the current treatment was an allyven dressing to be changed every 3 days. Nurse # 5 was unable to locate an MD order for the treatment and confirmed that there was not a treatment recorded on the February, 2017 MAR or TAR or on the 3/2017 MAR or TAR. Nurse # 5 revealed that she has last performed the sacral treatment of Resident # 179 on the previous Friday and that the area was open, the tissue was pink and was observed to be healing. Nurse # 5 stated that she performed wound care at the time with an allyven dressing. Nurse #5 revealed that she had not documented the treatment on the TAR, MAR or in a nurse progress note, but that she had done the treatment. Nurse #5 reviewed the medical record for Resident # 179 and confirmed that there was no documentation of the wound treatment order or any documentation of wound care being completed. Nurse # 5 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 24	F 514		

the only documentation of any pressure ulcer or skin care treatment was on the skin assessments of Resident # 179 and that wound care was just something that the nurses knew had to be done.

An interview with the Director of nurses (DON) on 03/08/2017 at 10:30 AM revealed that the nurse that admitted Resident # 179 on 01/ 27/2017 did not document the presence of a pressure ulcer and that a wound record dated 02/08/2017 revealed that Resident # 179 had acquired a stage 3 pressure ulcer. The DON confirmed that there was no pressure ulcer treatment recorded on either the treatment administration records (TARs) or medication administration records (MARs) dated from 02/08/2017 through 03/08/2017 and that there was no MD order for pressure ulcer care (treatment) during the same time for Resident # 179. The DON revealed that weekly skin assessments are completed for all residents every week by the licensed nurse assigned to the resident at the time of the scheduled weekly wound assessment. The DON stated that all licensed nurses could assess and stage pressure ulcers. The DON stated that the facility MD was updated of any skin integrity concerns, but that the MD did not perform weekly wound rounds and that he only observed wounds as requested by the nurse staff if the nurse staff had questions or concerns about any wound status. The DON confirmed that the MD had written a progress note dated 02/08/2017 related to Resident # 179 having a stage 2 pressure ulcer. The DON revealed that the pressure ulcer dressing had been changed in the early morning of 03/08/2017 and that the DON had observed the pressure ulcer on the sacrumf Resident # 179 and described that it had progressed to a stage 2 pressure ulcer with pink, healthy tissue and was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 25	F 514		

almost healed and that the nurse assigned to Resident # 179 had cleaned the wound and applied an allevyn dressing as per the facility wound care protocol. The DON revealed that she knew Resident # 179 had no pressure ulcer on admission, but could not recall when she had been made aware that Resident # 179 had a stage 3 pressure ulcer on the sacrum. The DON stated that the expectation was that the nurse notified the DON as soon as possible of any resident having a pressure ulcer so that the DON could assess the skin, follow up with the MD and be certain that treatment orders were in place and that care interventions be initiated.

An interview with the facility nurse consultant on 03/08/2017 at 5:16 PM revealed that all licensed nurses could stage wounds.

On 03/09/2017 at 7:46 AM an interview was conducted with Nurse #2. Nurse #2 revealed that she had performed wound care to Resident # 179 one day the previous week. Nurse #2 stated that she had performed the dressing change because Resident # 179's dressing had been soiled and needed to be changed. Nurse #2 revealed the pressure ulcer on the sacrum of Resident # 179 was healing from a stage 3 pressure ulcer. Nurse #2 stated that she had removed the soiled dressing and cleansed the wound with wound cleanser and then applied an allevyn wound dressing. Nurse #2 was unable to confirm that the wound care she had performed had been documented anywhere in the medical record of Resident # 179 which included the nurse progress notes, the TARs or MARs which she reviewed back to 02/08/2017. Nurse #2 stated that she did not document any wound care for Resident # 179 and when asked, Nurse #2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 26	F 514		

that there was no MD order in the medical record and explained that she was aware of the type of treatment that was being performed on the sacral wound of Resident # 179 because it was information that the nurses shared with one another during shift report.

An interview was conducted with the Staff Development Coordinator (SDC) on 03/09/3017 at 7:54 AM revealed that Resident # 179 had developed an acquired stage 3 pressure ulcer in the facility on 02/08/2017and that the MD and the family of Resident # 179 were made aware at that time. The SDC confirmed that a treatment order had not been obtained by the MD and had not been transcribed to the MARs or TARs of Resident # 179 which is where all treatments should be transcribed. The SDC also revealed that he was not able to locate any progress note documentation of wound care for the stage 3 pressure ulcer for Resident # 179 except on the weekly skin assessment reports or assessments and that the facility protocol had not been followed.

An interview with the facility nurse consultant on 03/09/2017 2:13 PM revealed that if the facility standing orders were implemented, that the standing orders would be input into the electronic medical record and would be prompted to transfer the order to an appropriate area, such as the treatment record for that particular resident and that standing orders could not be randomly chosen and implemented without an area in the electronic record for the nurse to document that the standing order was being followed.

An interview with the MDS nurse was conducted on 03/09/2017 at 3:02 PM and revealed that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 27 based on the weekly skin assessments and wound records, the MDS could not be coded based on nurse and MD documentation and that Resident # 179 had no MD documentation of a pressure ulcer until 02/14/2017, which was after the MDS assessment date 02/03/2017. The MDS nurse revealed that there had never been an MD order written for a treatment of a pressure ulcer for Resident # 179 and that there was no treatment to code on the MDS. On 03/09/2017 at 4:37 PM a follow up interview with the DON revealed that her expectation was that the nurses follow the wound care protocols and standing orders of the MD and that all resident's skin be assessed and treatments and other skin care interventions be initiated as soon as possible.	F 514		
F 520 SS=C	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance	F 520		4/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 28 committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility's Quality Assessment and Performance Improvement committee (QAPI) failed to implement, monitor and revise as needed the action plan developed for the recertification survey dated 3/31/16 in order to achieve and sustain compliance. The facility had a repeat deficiency on Posted Nurse Staffing Information for the recertification survey dated 3/9/17. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to F356: Posted Nurse	F 520	How corrective action will be accomplished for each resident found to have been affected by the deficient practice: In reference to F356 – No residents were affected by deficient practice. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: Director of Nursing and designees are to be educated by regional nurse consultant on posted nurse staffing and census.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 29 Staffing Information. Based on staff interview and record review the facility failed accurately report the resident census and staffing figures on the Staff Posting for 4 of 4 survey days on all 3 shifts, failed to exclude the residents residing in non-Skilled Nursing Facility level of care beds from the census total, and failed to exclude the staff time allocated to those residents from the staff posting figures for the designated Skilled Nursing Facility level of care beds. During the previous recertification federal survey of record, 3/31/16, the facility was cited for a deficiency at F356 for failing to post the daily facility nursing staffing in an area that could easily be seen or located by the residents, staff and visitors for three days of the recertification survey Interview with the Administrator on 3/9/17 at 5:00 PM revealed that he was aware of the requirement to include only SNF residents and designated nursing staff in the staff posting figures. He acknowledged that if the Staff Positing was indicating 91 or 92 residents it was incorrect and that the staff hours for those residents that were not in SNF beds should also be excluded. He indicated he had some thoughts on how it to ensure accuracy of the Staff Posting and that he would investigate and resolve the issue.	F 520	Measures to be put in place or systemic changes made to ensure practice will not re-occur: To ensure compliance with this requirement, the administrator reviewed both the findings for F356 (as listed on Form 2567) as well as the Interpretive Guidelines contained in Appendix PP, Publication 7, State Operations Manual. He determined that the facility complies with posting requirements except as cited on the 2567. This includes the requirement of prominent placement, as cited in 2016. The current 2567 correctly identified the deficiency of comingling assisted living residents with skilled nursing residents in the total census and staffing hours reported, which apparently had been facility policy since the inception of the daily staff posting requirement 15 or so years ago. To ensure compliance with the requirement of only reported skilled nursing census & staffing, the administrator developed a simple reporting format for both census and staffing, as well as a basic spreadsheet to assist in calculating hours. The facility's nurse consultant educated the center's administrative nurses (DON, SDC, Unit Managers, nurse supervisors) on their use on March 27th. Residents in Rooms 221, 222, 223, 224 & 225 are assisted living (or Home for the Aging) level of care and are specifically excluded from the overall census & staffing when generating the Posted Nurse Staffing. Administrator and/or Director of Nursing will conduct audit of daily nurse staffing summary for completeness weekly for 12 weeks then once every two weeks three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 30	F 520	Completion of the Daily Staff Posting is now included for all administrative nurse hires and is conducted by the facility's nurse consultant or designee. The administrator is responsible for compliance. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed as an action item at the center's Weekly Risk Quality Assurance Meeting for 12 weeks, then bi-weekly for 3 months. The findings of these reviews will be reported to the center's Quarterly QA&A Committee for two meetings (July 17 and October 17) for further resolution if needed. The administrator will conduct a comprehensive review of all the interpretive guidelines in January 2018 for compliance and report findings of same to the QA&A Committee at its January 2018 meeting.	