STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		2/20/18

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

Electronically Signed | 02/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to notify the Responsible Party (RP) until the following day that a cognitively impaired wandering resident had been found outside unsupervised for 1 of 1 sampled residents (Resident #1). Findings included: Review of Resident #1's Admission Minimum Data Set (MDS) dated 01/14/18 revealed an admission date of 01/08/18 and diagnoses of Alzheimer's disease, depression, and non-Alzheimer's dementia. Resident #1 was severely cognitively impaired. Review of the General Progress Note dated 01/15/18 revealed Resident #1 made two attempts to open the door and go out. Consent was provided by Resident #1's family for placement of a wander device bracelet which was placed on the left ankle. Review of the Progress Notes dated 01/24/18 did not reveal any note that Resident #1 had been found outside the facility. Review of the Risk Management System report dated 01/25/18 and created by the DON, revealed	F 580	The filing of this plan of correction does not constitute an admission that the deficiencies alleged, did in fact exist. This plan of correction is filed as evidence of the facility's desire to comply with regulations and to provide high quality care. Nurse #1 failed to notify the Responsible Party of a significant event on the evening of 01/24/18. All licensed staff were in-serviced to immediately notify the Responsible Party of all incidents, significant changes and order changes and document notification in the appropriate systems. The interdisciplinary team will monitor all progress notes daily and the weekend supervisor will review on the weekend to ensure appropriate documentation and follow up with Responsible Party has been completed timely, to remain compliant. This process shall be ongoing. Findings of these audits will be reviewed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 580	Continued From page 2 that on 01/24/18 at approximately 10:30 PM Resident #1 exited the loading dock door and was found sitting on the loading dock by staff. Resident #1's physician was notified on 01/24/18 at 10:45 PM. Resident #1's RP was not notified until 01/25/18 at 8:20 AM. In an interview on 01/30/18 at 6:19 PM Nurse #1, who cared for Resident #1 the evening she was found outside, indicated she was approached by Resident #1's Nursing Assistant (NA #1) who told her she was unable to locate Resident #1 after providing care for another resident. At approximately 10:40 PM Nurse #1 looked down the hallway outside Resident #1's room and was able to see her through the glass door sitting in a wheelchair on the loading dock. She indicated she notified the DON that Resident #1 had been found outside on the loading dock but did not document the incident, call Resident #1's physician, or notify Resident #1's RP. She stated the DON told her she would take care of all that. She indicated she had assessed Resident #1 but had found no injury. In a telephone interview on 01/31/18 at 11:07 AM Resident #1's RP stated the facility should have called her when they discovered that Resident #1 had left the building unsupervised. She indicated she was glad Resident #1 had received no injuries but hoped the facility was able to fix the problem with the door alarm. In an interview on 01/31/18 at 12:45 PM the DON stated she told Nurse #1 not to notify Resident #1's RP of the incident. She indicated that since it was 11:00 PM and Resident #1 had sustained no injury, she felt a telephone call in the morning would be sufficient.	F 580	at the Quality Assurance Performance Improvement Meetings monthly for three months. A report will be submitted to the Performance Improvement Committee at which time the committee will reassess the need for ongoing monitoring. The person responsible for this plan of correction os the Center Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to supervise a cognitively impaired wandering resident who had known exit-seeking behaviors from exiting the facility unsupervised for 1 of 3 sampled residents (Resident #1). The immediate jeopardy began on 01/24/18 when Resident #1 exited from the facility without staff's knowledge and was found outside on the loading dock. Immediate jeopardy was removed on 02/01/18 1:30 PM when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level D (isolated, not actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring and that all staff have been in-serviced. Findings included: Review of Resident #1's Admission Minimum Data Set (MDS) dated 01/14/18 revealed an admission date of 01/08/18 and diagnoses of Alzheimer's disease, depression, and non-Alzheimer's dementia. Resident #1 was severely cognitively impaired. The assessment revealed Resident #1 did not wander.	F 689	At approximately 10:30PM on 01/24/18 the LPN was sitting at the desk and got up to go begin shift change. As she was walking down the 100 hall a CNA stopped her and stated, "she had seen the resident a few minutes ago but now could not find her." LPN asked a second CNA if she had seen her and the second CNA stated she had seen her approximately 5 minutes ago while taking the laundry cart down the hall. The LPN and two CNAs began facility search looking for the resident. The second CNA saw the resident sitting outside the doorway of her room located on the 100 hallway. She was sitting stationary at the time the second CNA seen her outside of her room doorway. Resident was not heading toward the loading dock. As the LPN neared the end of the hall of the 100 hallway, she saw resident through the glass door sitting in her wheelchair on the concrete slab outside of the facility door. The LPN immediately went outside and returned the resident inside the center. This was the same hall the	2/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 Review of the Skilled Nursing Progress Note dated 01/14/18 revealed Resident #1 was confused and packed up all her clothing into her suitcase. Review of the General Progress Note dated 01/15/18 revealed Resident #1 made two attempts to open the door and go out. Consent was provided by Resident #1's family for placement of a wander device bracelet which was placed on the left ankle. Review of the Elopement Evaluation conducted 01/16/18 revealed Resident #1 was able to ambulate or propel a wheelchair independently and had attempted to pack her belongings. Resident #1 was impulsive, restless and agitated and had a wander device bracelet. Review of Resident #1's Care Plan dated 01/16/18 revealed she was at risk for elopement as she had made one or more attempts to leave the facility due to cognitive loss and dementia. The goal for Resident #1 was that she be kept safe within the facility every day. Interventions included diverting Resident #1 by providing alternative activities and by checking the placement and the function of the wander device. Review of the Physician Orders dated 01/18/18 revealed an order for a wander device for Resident #1 due to poor safety awareness. The device was to be checked every shift for placement and function. Review of the Treatment Administration Record (TAR) dated 01/18/18-01/26/18 revealed Resident #1's wander device was checked every	F 689	resident was assigned to. The LPN then took the resident to her room and completed a body assessment with skin check and vital signs. The assessment and vital signs were normal. The wander guard device was functioning appropriately. The wander guard alarm did not sound when the resident reentered the facility through the loading dock door. The wander guard device was placed on the residents left ankle. The LPN checked the wander guard bracelet with the Code Alert Transmitter Tester. The staff did not check the loading dock door for functioning due to previous malfunction and submitted a work order to Maintenance for repair. The LPN notified the Center Nurse Executive of the incident. The LPN informed the other on-coming nurse of the incident at change of shift so the resident could be monitored throughout the night. The LPN went throughout the facility and checked all residents wearing wander guards; all were in bed and accounted for. The resident was assisted to bed and provided with more frequent room checks. On the morning of 01/2/18 the Maintenance Director inspected the door according to a work order received from the previous night on 01/24/18. Work order stated that the wander guard system is not locking or alarming back door. The Maintenance Director checked and moved the antennas down on the door frame for lower coverage and tested the function of the alarm, after the incident. Alarm was tested and was 100%	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

shift for placement and function by the nurses.

Review of the Risk Management System report dated 01/25/18 revealed that on 01/24/18 at approximately 10:30 PM Resident #1 exited the facility's loading dock door and was found sitting on the loading dock by staff. Resident #1's wander device was in place. The wander device system was found to not be sensitive enough to pick up a signal from the device on Resident #1's ankle. On 01/25/18 all of the wander devices were tested and were working. The antenna for the wander system at the loading dock door was adjusted to make it more sensitive to the devices worn by wandering residents.

Review of the Repair Requisition dated 01/24/18 revealed Resident #1's wander device was not setting off the alarm or locking the door. On 01/25/18 the Maintenance Director wrote that the antenna was lowered for lower coverage, rechecked, and was working correctly.

Review of the Performance Improvement meeting note dated 01/25/18 revealed that all wander elopement device bracelets and systems were checked and in appropriate working order. It was noted that the Maintenance Director moved the system antennas down at the loading dock door to increase the sensitivity. There was also a signed statement from the Maintenance Director that the devices and systems had been tested, were in working order, and that the antenna at the loading dock door had been moved to increase its sensitivity.

Review of the Change in Condition Follow-up Note dated 01/25/18 revealed Resident #1 continued to have confusion and wandering

functional. The alarm was tested by the residents wander guard placed on the residents body, on each resident that has a wander guard placed. The wander guard for the resident was checked by nursing for placement and functionality on day shift.

Resident was discharged on 01/28/18. Resident had a planned safe discharge due to insurance coverage ending. Resident was discharged on 01/28/18 to ALF, per family request.

The resident wearing the wander guard bracelet on her ankle, which was in a position that the antennas did not detect. The antennas were moved lower on 01/25/18, by the Maintenance Director, to increase the sensitivity of the system. The wander guard system was installed and used per manufacturer instructions. There were no manufacturer instructions regarding bracelet placement. The facility maintains a log of expiration dated for the wander guard bracelet and the bracelet is replaced with a new one prior to the expiration date. There are no batteries connected to the system. The system is connected to facility power and emergency generator. The antenna placement on the door was not sensitive enough for the placement of the wander guard bracelet on the ankle. Once antennas were moved down it increased the sensitivity and worked appropriately.

100% of all staff (Nursing, Housekeeping, Dietary, Business Office and Rehab) was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

behavior. Resident #1 was exit seeking and became agitated when told she could not go out the doors.

Review of the Skilled Nursing note dated 01/26/18 revealed Resident #1 was constantly exit seeking and was frequently seen pulling and pushing on door handles.

Review of the General Progress Note dated 01/27/18 revealed Resident #1 was discharged from the facility in a previously planned discharge.

In an observation and interview on 01/30/18 at 3:10 PM the Maintenance Director (MD) produced the January 2018 wander system log book which revealed the wander system door alarms were checked daily and functioned correctly. He stated he performed the system check during the week and the Weekend Supervisor checked the system on the weekends. The MD proceeded to perform a test of the wander elopement system. While holding the wander device in his hand he walked up to the loading dock door and the door locked. He then turned around and walked down the hallway approximately ten feet and turned around. The door unlocked. While still holding the wander device, he approached the door and pushed on it. The door did not lock and no alarm sounded to signal a wander device had exited the building when he walked out the door.

In an interview immediately following the observation on 01/30/18 at approximately 3:30 PM the MD indicated if a resident who had a wander device attempted to open an alarmed door, the door should lock. He indicated that if the resident moved away from the door enough so

in-serviced on Elopement Procedure, which includes assessing of residents which sows signs of wandering/exit seeking behaviors, responsiveness to alarms, placement of wander guard bracelets, bracelet testing every shift, testing of bracelets to actual doors daily, on 01/31/18 and 02/01/18, Nurse Practice Educator and Center Nurse Executive. Staff in-service also included redirecting resident who wander off their assigned hallway with notification to the charge nurse. All licensed nurses were in-serviced on the appropriate testing of wander guard door alarms. The Maintenance Director was in-serviced on 01/31/18, on appropriate testing of door alarms by the Center Executive Director and the Center Nurse Executive. The Maintenance Director and the Social Service Director rechecked other residents wearing wander bracelets for proper position, function and expiration dates for the device. Maintenance Director has also rechecked all appropriate doors for audible alarm when the door is open prior to the resident entering the space, all doors functioning appropriately.

Nursing will continue to check residents for appropriate placement and function of wander bracelets every shift. Nursing will also begin testing door alarms on the night shift for the next 30 days to assure proper function. Testing bracelet will be used at each door to ensure lock down and audible alarm. Antennas were relocated lower on the door frame to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 the door would unlock and then approached the door again, the door may remain unlocked and allow the resident to exit the building without the alarm sounding. He stated the loading dock door was acting up during the test and that the door was not secure. The MD indicated when he checked the wander system he held a wander device in his hand but did not check the sensitivity of the device if it was on the lower leg. An observation was conducted on 01/31/18 at approximately 3:35 PM of the hallway leading to the loading dock, the loading dock itself, and the outside surrounding area with the MD after the interview, revealed the distance from Resident #1's room to the loading dock door was approximately 123 feet. The loading dock was approximately 2 feet from the ground and a metal railing was on the back to prevent a drop off. The loading dock angled to the ground and approximately 112 feet straight ahead from the bottom of the ramp was a barbed wire fence. Approximately 75 feet to the right of the bottom of the loading dock ramp was a driveway and from the driveway to the road was approximately 240 feet. In an interview on 01/30/18 at 3:46 PM the Director of Nursing (DON) stated Resident #1 was not appropriate for placement in the facility. She indicated a planned discharge to another facility was being worked on at the time of the elopement at the request of the resident's family. In an interview on 01/30/18 at 6:19 PM Nurse #1, who cared for Resident #1 the evening of the elopement, indicated Resident #1 would verbalize that she wanted to leave the facility and would attempt to open the exit doors leading outside.	F 689	ensure proper functioning of the bracelet placement, whether on the wrist or the ankle. Maintenance Director will use the test bracelet at different levels, ie: ankle and wrist, to ensure proper lock down and alarm. Maintenance Director will continue to conduct daily checks on all door alarms Monday through Friday. Weekend Manager or weekend nursing supervisor will conduct door alarm checks on Saturday and Sunday. Testing bracelet will be used at each door to ensure lock down and audible alarm. Findings of these audits will be reviewed at the Quality Assurance Performance Improvement Meetings monthly for three months. A report will be submitted to the Performance Improvement Committee at which time the committee will reassess the need for ongoing monitoring. The person responsible for this plan of correction is the Center Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

She stated on the night of the elopement she was approached by Resident #1's Nursing Assistant (NA #1) who told her she was unable to locate Resident #1 after providing care for another resident. NA #1 indicated to Nurse #1 that she had seen Resident #1 in the hallway last at approximately 10:30 PM. Nurse #1 and NA #1 began to look for Resident #1 and questioned other staff if they had seen Resident #1. She indicated the door alarm was not sounding. At approximately 10:40 PM Nurse #1 looked down the hallway outside Resident #1's room and was able to see her through the glass door sitting in a wheelchair on the loading dock wearing a long sleeve T-shirt, long pants, and shoes and socks but no jacket. Nurse #1 stated it was a cold and clear night. Nurse #1 stated she opened the loading dock door and brought Resident #1 back inside the facility. She stated the door alarm did not sound when Resident #1 was brought back into the facility and that it should have. Nurse #1 stated she assessed Resident #1 for injury and checked her vital signs. Resident #1's temperature was 97.4 degrees Fahrenheit. She indicated she notified the DON that Resident #1 had been found outside on the loading dock but did not document the incident or check Resident #1's wander device or the door alarm for functionality. She stated that she did lock the loading dock door but that the door could still be opened from the inside with just a little added effort.

In an interview on 01/30/18 at 6:50 PM NA #1, who cared for Resident #1 the evening of the elopement, indicated Resident #1 had been saying all that day that she wanted to go home. She stated that at dinner time Resident #1 was carrying around her picture frames so she could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

take them with her. NA #1 indicated she had informed Nurse #1 that Resident #1 was carrying around the picture frames. NA #1 stated she would always check to see where Resident #1 was after providing care to another resident because she was determined to go home and would attempt to open the exit doors. She indicated that even though Resident #1 used a wheelchair, she would stand up and try to push hard on the exit doors to try and open them. NA #1 indicated she had tried to keep a close eye on Resident #1 that night because she had been trying to get out of the facility. NA #1 indicated she had been unable to locate Resident #1 and had last seen her at about 10:30 PM. NA #1 reported to Nurse #1 that she was unable to locate Resident #1 and they both began searching for her. NA #1 indicated that Nurse #1 saw Resident #1 through the glass of the door, sitting in a wheelchair on the loading dock. She stated the door alarm was not sounding and did not sound when Resident #1 was brought back into the building. NA #1 stated that the wander devices used for wandering residents did not work all the time and that the DON and the MD had been told of the problem. She could not remember when she had last informed the DON or the MD of problems with the door alarm.

In an interview on 01/30/18 at 7:09 PM NA #2 indicated she had been working the night Resident #1 had been found on the loading dock. She stated she had seen Resident #1 sitting in the doorway of her room at about 10:25 PM when she had been on her way to the laundry room. NA #2 indicated NA #1 informed her they could not locate Resident #1. She stated she went to assist in the search and she and Nurse #1 saw Resident #1 through the glass of the door sitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

on the loading dock in her wheelchair. She stated no alarm was sounding and when Nurse #1 brought Resident #1 back inside the alarm still did not sound. NA #2 said it was "pretty cold" outside and that Resident #1 was wearing a long sleeve shirt and pants, shoes and socks, but no jacket. She stated she wrapped a blanket around Resident #1 and took her to her room and assisted NA #1 to put the resident in bed.

In an interview on 01/30/18 at 7:45 PM the DON stated that she knew Resident #1 had exit seeking behaviors. She indicated she had been informed by staff that the wander device alarms did not always work. She indicated that each time it was reported the alarms did not work the doors would be tested and they always worked. She was unable to recall when she had last been informed of problems with the door alarms.

In an observation and interview on 01/31/18 at 8:50 AM the wander device door alarm on the loading dock door had been changed to a magnet lock door that could only be unlocked with a code or with an emergency opener. The MD demonstrated that the door was functioning and remained locked during attempts to open it. He stated no outside vendors had been asked to come in to check the wander device system as this was the only time he was aware of that the system did not function correctly. He indicated that with the previous system the antennae had not been picking up the signal if the device was on the resident's lower leg.

In an observation and interview on 01/31/18 at 10:42 AM Nurse #4 removed the wander device code alert box from the medication cart. She approached each of her assigned residents and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

held the box to the resident's wander device. The green indicator lit up and the alarm sounded. Nurse #4 stated that if the green light lit up and the alarm went off it meant the device was working appropriately. She indicated the wander devices were checked each shift by the nurses and the test was documented on the Treatment Administration Record (TAR). She indicated that she had never had an issue with a resident's wander device.

The Administrator was notified of the immediate jeopardy at 3:28 PM on 01/31/18. The facility provided a credible allegation of immediate jeopardy removal on 02/01/18 at 1:30 PM. The allegation of immediate jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy Removal:

1. At approximately 10:30 PM on 01/24/18 a LPN (Licensed Practical Nurse) was sitting at the desk and got up to go begin shift change. As she was walking down the 100 hall a NA stopped her and stated "she had seen resident a few minutes ago but now could not find." The LPN asked a second NA if she had seen her and the second NA stated she had "seen her approximately 5 minutes ago while taking the laundry cart down the hall." The LPN and two NAs began a facility search looking for the resident. The second NA saw the resident sitting outside the doorway of her room located on the 100 hallway. She was sitting stationary at the time the second NA saw her outside of her room doorway (Room 109B). The resident was not heading toward the loading dock.
As the LPN neared the end of the hall of the 100

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

hallway, she saw the resident through the glass door sitting in her wheelchair on the concrete slab outside of the facility door. The LPN immediately went outside and returned the resident inside the center. This was the same hall the resident was assigned to.

The LPN then took the resident to her room and completed a body assessment with skin check, took vitals and checked the Wander Guard Device. The assessments and vitals were all normal. The Wander Guard Device was functioning appropriately. The wander guard alarm did not sound when the resident reentered the facility through the loading dock door. The wander guard device was placed on the residents left ankle. The LPN checked the wander guard bracelet with the Code Alert Transmitter Tester. The staff did not check the loading dock door for functioning due to previous malfunction and submitted a work order to Maintenance for repair. The LPN notified the Center Nurse Executive of the incident. The LPN informed the other on-coming nurse of the incident at change of shift so the resident could be monitored throughout the night. The LPN went throughout the facility and checked all residents wearing Wander Guards; all were in bed and accounted for. The resident was assisted to bed and provided with more frequent room checks.

On the morning of 01/25/18 the Maintenance Director inspected the door according to a work order received from the previous night on 01/24/18. The work order stated that the Wander Guard system was not locking or alarming the back door. The Maintenance Director checked and moved the antennas down on the door frame for lower coverage and tested the function of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

alarm, after the incident. The alarm was tested and was 100% functional. The alarm was tested by using the residents wander guard placed on the residents body, on each resident that had a wander guard placed. The wander guard for the resident was check by nursing for placement and functionality on day shift.

The resident was discharged on 01/27/18. The resident had a planned safe discharge due to an (name of insurance company) insurance cut on 01/26/18. The resident was discharged on 01/27/18 to (name of an assisted living memory care unit), per family request.

The resident was wearing the Wander Guard Bracelet on her ankle, which was in a position that the antennas did not detect. The antennas were moved lower on 01/25/18, by the Maintenance Director, to increase the sensitivity of the system. The wander guard system was installed and used per manufacturer instructions. There are no manufacturer instructions regarding bracelet placement. The facility maintains a log of expiration dates for the wander guard bracelet and the bracelet is replaced with a new one, prior to the expiration date. There are no batteries connected to this system. The system is connected to facility power and emergency generator. The antenna placement on the door was not sensitive enough for the placement of the wander guard bracelet on the ankle. Once the antennas were moved down it increased the sensitivity and worked appropriately.

2. 100% of all staff (Nursing, Housekeeping, Dietary, Business Office and Rehab) was in-serviced on Elopement Procedures, which included assessing of residents which showed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

signs of wandering/exit seeking behaviors, responsiveness to alarms, placement of Wander Guard Bracelets, bracelet testing every shift, testing of bracelets to actual doors daily, on 01/31/18 and 02/01/18, by NPE (Nurse Practice Educator) and CNE (Center Nurse Executive). Staff in-service also included redirecting residents who wander off their assigned hallway with notification to the charge nurse. All licensed nurses were in-serviced on appropriate testing of Wander Guard door alarms. The Maintenance Director was in-serviced on 01/31/18, on appropriate testing of door alarms by CED (Center Executive Director) and the CNE. The Maintenance Director and the Social Service Director rechecked other residents wearing wander bracelets for proper position, function and expiration dates for the device. Maintenance Director has also rechecked all appropriate doors for audible alarm when the door was open prior to the resident entering the space, all doors functioned appropriately.

3. Nursing will continue to check residents for appropriate placement and function of wander bracelets every shift. Nursing will also begin testing door alarms on the night shift for the next 30 days to assure proper function. A testing bracelet will be used at each door to ensure lock down and audible alarm. Antennas were relocated lower on the door frame to ensure proper functioning of the bracelet placement, whether on wrist or ankle. The Maintenance Director will use the test bracelet at different levels, ie: ankle and wrist, to ensure proper lock down and alarm.

The Maintenance Director will continue to conduct daily checks on all door alarms Monday

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

through Friday. The Weekend Manager or weekend nursing supervisor will conduct door alarm checks on Saturday and Sunday. A testing bracelet will be used at each door to ensure lock down and audible alarm.

4. The person responsible for this credible allegation of immediate jeopardy removal was the Center Executive Director. The allegation of immediate jeopardy removal date was 02/01/18.

The credible allegation was verified on 02/01/18 at 4:55 PM as evidenced by:

In an observation with the MD on 02/01/18 beginning at 12:15 PM, doors leading to the outside of the facility were checked for functionality. The new magnet lock on the loading dock door remained locked when approached by the MD holding a wander device.

In an interview on 02/01/18 at 12:28 PM the MD stated that the placement of the wander device did not matter. He indicated it could be placed on either the wrist or the ankle.

In an interview on 02/01/18 at 3:15 PM the Activities Director stated she had been in-serviced on elopements and alarms.

In an interview on 02/01/18 at 3:46 PM Nurse #2 stated she had been in-serviced on elopement and the new way of checking the wander alarmed doors.

In an interview on 02/01/18 at 3:49 PM Nurse #3 stated she had been in-serviced on elopement and how to check the wander devices with the alarm monitor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16 In an interview on 02/01/18 at 3:51 PM NA #3 indicated she had been in-serviced on elopement and wandering residents. In an observation on 02/01/18 beginning at 12:42 PM the six residents who had wander devices were brought to the front door (only door with the wander system) and the functionality of the wander system and devices was checked. The system and devices locked the door when approached. When the residents were moved back from the door and the door lock was disengaged, staff opened the door and attempted to wheel the residents out the open door. The alarm sounded each time. Manufacturer instructions for the wander system and devices were reviewed. It was verified that placement of the wander devices could be placed on either the wrist or the ankle. The Door Inspection for Code Alert log for 02/01/18 was reviewed and revealed the front and loading dock doors had passed their lock down and alarm tests. Review of the February Treatment Administration Records (TAR) for each of the six residents revealed the wander devices had been checked for placement and functionality.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		2/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 758	Continued From page 17	F 758		

but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 758	Continued From page 18 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff and physician interviews the facility failed to follow a gradual dose reduction (GDR) for an anti-psychotic medication as recommended by the pharmacist and ordered by the physician for 1 of 1 residents (Resident #3) whose record was reviewed. Findings included: Resident #3 was admitted to the facility on 03/02/17 with diagnoses of depression, psychotic disorder, osteoporosis and hypertension according to the annual Minimum Data Set (MDS). Review of the September 2017 Medication Administration Record (MAR) revealed Resident #3 received Haldol 0.25 mg (milligrams) every night at bedtime and had not been changed to an every other day dose. Review of the pharmacist Consultation Report for 09/01/17-09/30/17 and dated 09/26/17 revealed a recommendation to Resident #3's physician to consider a GDR of Haldol (an antipsychotic medication). The recommended change in dosage was to be 0.25 mg every other day for two weeks and then to discontinue the medication. Review of the pharmacist Consultation Report for 10/01/17-10/31/17 and dated 10/31/17 revealed a comment from the pharmacist that Resident #3's physician had agreed to the recommendation to	F 758	The facility failed to carry out consultant pharmacist recommendation and physicians order for a gradual dose reduction for an anti-psychotic medication for resident #3. The facility implemented the following procedure to ensure that all pharmacy consults are signed and followed through to remain compliant with the regulation. 1. The procedure will include-the Center Nurse Executive will make copies of the pharmacy consults. 2. The Center Nurse Executive will give copies of the pharmacy consults to the RN Supervisor. 3. The RN Supervisor will obtain medical doctor (MD) signature on all consults. 4. The RN Supervisor will bring signed copies of the pharmacy consults back to the Center Nurse Executive and together they will check for completion against original pharmacy consultations. 5.Once the pharmacy consults are doubled checked for accuracy, the RN Supervisor will put new orders in Point Click Care (PCC). This process will be ongoing to ensure proper compliance. Licensed staff were educated by the Nurse Practice Educator on the need to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 758	Continued From page 19 decrease and then discontinue the dose of Haldol on 09/29/17 but that the order was still active. Review of the annual MDS dated 10/01/17 revealed Resident #3 was not cognitively impaired and received 7 days of anti-depressant and anti-psychotic medications during the 7 day look back period. Review of the October 2017 MAR revealed Resident #3 received Haldol 0.25 mg every night at bedtime for the whole month and had not been changed to an every other day dose or discontinued as ordered. Review of the November 2017 MAR revealed Resident #3 received Haldol 0.25 mg every night at bedtime through 11/09/17. The medication dosage was increased to 0.5 mg every night at bedtime through the rest of the month due to an increase in behaviors at night. In an interview on 02/01/18 at 11:30 AM the Director of Nursing (DON) stated she received the recommendations from the pharmacist and passed them on to the Registered Nurse (RN) Supervisor. She indicated she did not follow up on any of the recommendations to make sure that they were addressed. She stated she had been unable to locate the 09/29/17 signed recommendation from the physician that the pharmacist had written about. In an interview on 02/01/18 at 11:40 AM the RN Supervisor indicated she did not keep a log of the recommendations made by the pharmacist and did not follow-up on them. She stated she faxed the recommendations to the physicians but had no way to track what she sent.	F 758	follow up on pharmacy recommendations for timely physician notification and changes to the orders as appropriate. Findings of these audits will be reviewed at the Quality Assurance Performance Improvement Meetings monthly for three months. A report will be submitted to the Performance Improvement Committee at which time the committee will reassess the need for ongoing monitoring. The person responsible for the plan of correction is the Center Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	877 HILL EVERHART ROAD LEXINGTON, NC 27295

(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 758	Continued From page 20	F 758		

In an interview on 02/01/18 at approximately 2:30 PM Resident #3's physician confirmed he had agreed with the pharmacist's recommendation to decrease and then discontinue the Haldol in September 2017 and that his order had not been carried out. He indicated he would have signed the recommendation and placed it in his folder at the facility for the staff to input into the computer. He stated he expected his orders to be followed and that a physician signed pharmacist recommendation was considered to be an order. Resident #3's physician stated that it was especially important that an antipsychotic medication order be followed because these medications required special handling with their use such as gradual dose reductions.

In a follow-up interview on 02/01/18 at 3:10 PM the RN Supervisor indicated that physicians had folders at the nursing desk. If they did not fax back the pharmacist recommendations they could place them in the folder when they were at the facility and she would gather them up and input the orders into the computer. She stated that since she was not responsible for following up on the recommendations, she did not know what had happened or why the order was missed.

In an interview on 02/01/18 at 4:55 PM the DON stated if a pharmacist recommendation was signed by a physician it became an order. She indicated she expected all physician orders to be followed. She indicated that someone should have followed up on the pharmacist recommendations. The DON indicated that when the RN Supervisor was not in the facility, she would make a log and check the recommendation off when it was received back from the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345333	A. BUILDING _____ B. WING _____	C 02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABBOTTS CREEK CENTER	**877 HILL EVERHART ROAD LEXINGTON, NC 27295**

(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 758	Continued From page 21 She stated it was her expectation that this process be followed by staff members who worked with the pharmacist recommendations. She indicated that at the present time there was no double check done to make sure pharmacist recommendations were signed, returned, and acted on.	F 758		