

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>AYDEN COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 SNOW HILL ROAD</b> <b>AYDEN, NC 28513</b>		
(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	
E 000	Initial Comments	E 000			
F 000	An unannounced COVID-19 Focused Survey was conducted on 03/15/22 through 03/16/22. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 8CQQ11	F 000			
F 584 SS=B	<p>An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 03/15/22 through 03/16/22. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p> <p>The complaint intake numbers were; NC00184993, NC00185876, and NC00185883.</p> <p>1 of the 8 complaint allegations was substantiated resulting in deficiency.</p> <p><b>Safe/Clean/Comfortable/Homelike Environment</b> CFR(s): 483.10(i)(1)-(7)</p> <p>§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can</p>	F 584		4/8/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/29/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>AYDEN COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 SNOW HILL ROAD</b> <b>AYDEN, NC 28513</b>		
(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 584	<p>Continued From page 1</p> <p>receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>§483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain walls in good repair for 3 of 3 resident rooms (Room #'s 601, 604 and 610) observed for environment.</p> <p>Findings included:</p> <p>1a. Room 601 was observed on 3-15-22 at 10:30am. The observation revealed deep gouges in the wall behind the resident's bed causing the</p>	F 584	<p>Ayden Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>AYDEN COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 SNOW HILL ROAD</b> <b>AYDEN, NC 28513</b>		
(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 584	<p>Continued From page 2 plaster to show.</p> <p>Observation of room 601 occurred on 3-15-22 at 3:15pm with the Maintenance Director and revealed deep gouges in the wall behind the resident's bed causing the plaster to show.</p> <p>1b. During an observation of room 604 on 3-15-22 at 10:35am, the resident's wall behind and to the right of his bed was observed to have several deep gouges allowing the dry wall and plaster to show.</p> <p>A second observation of room 604 occurred on 3-15-22 at 3:18 with the Maintenance Director and revealed the resident's wall behind and to the right of his bed had several deep gouges allowing the dry wall and plaster to show.</p> <p>1c. Observation of room 610 occurred on 3-15-22 at 10:40am. The observation revealed an approximate 4 inch long by 3-inch-wide hole at the bottom of the resident's wall to the left of her bed allowing a view inside the wall.</p> <p>During a second observation of room 610 on 3-15-22 at 3:20pm with the Maintenance Director, the observation revealed an approximate 4 inch long by 3-inch-wide hole at the bottom of the resident's wall to the left of her bed allowing a view inside the wall.</p> <p>The Maintenance Director was interviewed on 3-15-22 at 3:22pm. The Maintenance Director stated he was aware of the poor condition of the resident walls and explained he thought the gouges were coming from the resident beds being moved up and down. He also discussed wanting to place bumpers</p>	F 584	<p>Ayden Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Ayden Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>On 3-17-22, the Maintenance Director initiated repairs to resident room #601 . Repairs will be completed by 4-8-22</p> <p>On 3-17-22, the Maintenance Director initiated repairs to resident room #604. Repairs will be completed by 4-8-22</p> <p>On 3-17-22, the Maintenance Director initiated repairs to resident room #610. Repairs will be completed by 4-8-22</p> <p>On 3/16/22, the Maintenance Director and Supply Clerk completed an audit of all resident rooms to include room 601, 604, and 610. This audit is to identify any room that are in need of repair to include but not limited to damaged walls or areas in need or painting to maintain a safe, clean, comfortable and homelike environment. The Maintenance Director will address all concerns identified during the audit to include but not limited to repairing</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>AYDEN COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 SNOW HILL ROAD</b> <b>AYDEN, NC 28513</b>		
(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 584	Continued From page 3 behind the beds to prevent the damage, but he stated he had not had time to make the needed repairs.  During an interview with the Administrator on 3-15-22 at 4:50pm, the Administrator acknowledged there were repairs needed to the resident room walls, but he explained due to COVID he had not been able to bring contractors into the building to make the needed repairs.	F 584	damaged walls, painting or replacement of wallpaper when indicated. Repairs will be completed by 4/8/22.  On 3/16/22, the Facility Consultant and Director of Nursing completed an in-service with the Maintenance Director in regards to Maintaining a Homelike Environment with emphasis on timely repair of facility and resident rooms to maintain a safe, clean, comfortable and homelike environment and not resolving work orders in TELs system until repairs are completed.  On 3/16/22, the Staff Facilitator initiated an in-service with all staff in regards to Safe and Homelike Environment. Emphasis is the process for prompt reporting of any area in the facility in need of repair to include but not limited to damage to walls in resident rooms or peeling wallpaper/paint to maintain a safe, clean, comfortable and homelike environment. In-service will be completed by 4/8/22. After 4/8/22, any staff who has not received the training will complete the in-service on the next schedule work shift. All newly hired staff will be in-serviced during orientation in regards to Safe and Homelike Environment.  The Medical Records Director, Social Worker, and/or Supply Clerk will complete facility rounds to include all resident rooms weekly x 4 weeks then monthly x 1 month utilizing the Environmental Rounds Audit Tool. This audit is to identify any area in the facility in need of repair to		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/12/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345490</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/16/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>AYDEN COURT NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 SNOW HILL ROAD</b> <b>AYDEN, NC 28513</b>		
(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 584	Continued From page 4	F 584	include but not limited to damaged walls or areas in need or painting to maintain a safe, clean, comfortable and homelike environment. The Medical Records Director, Social Worker and/or Supply Clerk will complete a work order in TELs for all identified areas of concern and notify the Maintenance Director. The Maintenance Director will address all work orders submitted for concerns identified to include but not limited to repairing, painting walls when indicated. The Administrator will review and initial the Environmental Rounds Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.		