STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 000	INITIAL COMMENTS A complaint investigation was conducted on 12/28/22. Event ID: JOK211. The following intakes were investigated: NC00196164, NC00195996, and NC00195925. 1 of 10 allegations was substantiated.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and Medical Director interview the facility failed to obtain STAT (now) labs and a chest Xray for a resident that was experiencing shortness of breath and swelling as ordered by the Medical Director for 1 of 3 residents reviewed (Resident #1). The findings included: Resident #1 was readmitted to the facility on 01/20/22 and was discharged from the facility on 11/24/22. Resident #1's diagnoses included chronic obstructive pulmonary disease, respiratory failure, heart failure and others. Review of a quarterly Minimum Data Set (MDS) dated 09/23/22 revealed that Resident #1 was cognitively intact and required one person set up assistances with activities of daily living. No shortness of breath or rejection of care was noted on the MDS.	F 658	F 658 Professional Standards 1. Resident # 1 no longer resides at this facility 2. All residents with orders for labs have potential to be effected. Nursing Leadership completed an audit of all current resident's lab and X ray orders for the past 30 days to ensure that all ordered labs/X rays were obtained per order. 3. Nursing Leadership completed education for all licensed staff including FT, PT, PRN and Agency on the lab/X-ray process. This education will be included in new hire orientation for licensed staff and new agency licensed staff onboarding. Nursing Leadership will review lab orders and the lab tracking log 5 x week in the Clinical Morning Meeting to ensure that labs and X rays are carried out per order.	1/5/23

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

Electronically Signed | 12/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 658	Continued From page 1 Review of a physician order dated 11/07/22 read, STAT (now) portable chest X-ray 2 view, STAT complete blood count (CBC), Basic Metabolic Panel (BMP), and B-type natriuretic peptide (BNP). The order was signed off by Nurse #1 and indicated it was a verbal order from the Medical Director (MD). Review of Resident #1's medical record revealed no lab report for the STAT CBC, BMP, and BNP that was ordered on 11/07/22. There was also no chest Xray report from 11/07/22 noted in the medical record. Nurse #1 was interviewed via phone on 12/28/22 at 2:02 PM and confirmed that she was working on 11/07/22 and was the extra nurse in the facility. Nurse #1 stated that if she had entered orders from the MD, she would have either gotten them from the MD or someone had asked her to enter the orders. Nurse #1 could not recall how she obtained the STAT orders for Resident #1 on 11/07/22 but stated she entered the orders, but she did not draw the labs or order the chest Xray. Nurse #1 stated that if the facility had STAT labs and there was someone in the facility that could take them to the hospital to be processed then one of the nurses would draw the labs and someone would take them to the hospital. Nurse #1 stated if there was no one to take the lab to the hospital then they would send the patient to the Emergency Room (ER) to have the labs drawn. Nurse #1 again confirmed that she entered the STAT orders for Resident #1 on 11/07/22 but she did not obtain them and did not order the chest Xray. The MD was interviewed via phone on 12/28/22 at 3:55 PM. The MD stated that on 11/07/22	F 658	Lab orders are entered on the log by the receiving nurse and then monitored by nursing leadership to ensure the process is carried out and physician is notified of the results. 4. The ADON will audit all lab/ X ray orders 5 X week for 4 weeks, then weekly thereafter to ensure compliance. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 1/05/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 658	Continued From page 2	F 658		

someone from the facility he could not recall who had contacted him and reported that Resident #1 was having some shortness of breath, was refusing to take her Lasix (diuretic), and had some lower extremity swelling. The MD explained that because he was not in the facility at the time to see Resident #1, he was very concerned that she may be in heart failure or fluid overload, so he instructed the staff to obtain a STAT chest Xray and STAT CBC, BMP, and BNP to rule out heart failure. The MD explained he was scheduled to visit the facility on 11/08/22 and planned to evaluate Resident #1 when he came on 11/08/22. The MD stated that when he visited the facility on 11/08/22 he did inquire about the STAT labs but could not recall what the outcome of the labs were but stated when he evaluated Resident #1, she did not appear clinically to be in heart failure, and he was "less concerned" than the day before. He stated that he re-ordered the lab work to be done along with some other changes to Resident #1's medications. The MD stated that he fully expected the STAT lab work to be completed when he ordered it on 11/07/22 because he was not in the facility to lay eyes on Resident #1 and given her complaints it was very possible that she was in heart failure and that would require further treatment or transfer to the ER for evaluation.

A follow up interview was conducted with Nurse #1 via phone on 12/28/22 at 5:41 PM. Nurse #1 stated that she may have been the nurse that contacted the MD on 11/07/22. After checking her cell phone records Nurse #1 confirmed that she was the nurse that had contacted the MD regarding Resident #1. She stated that she could not recall all the details of the day but stated that Resident #1 was weak, having some shortness of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 658	Continued From page 3	F 658		

breath and her ankles were swollen. Nurse #1 confirmed that the MD had ordered a STAT chest X-ray, STAT CBC, BMP, and BNP and ordered daily weights. Nurse #1 stated "I would not have drawn the labs that would have been whoever had her that day." Nurse #1 was informed that Nurse #2 was scheduled to work on Resident #1's unit on 11/07/22 and she replied "that is who I would have reported the orders to, and Nurse #2 would have been responsible for drawing the labs and calling and scheduling the Xray to be done.

Nurse #2 was interviewed via phone on 12/28/22 at 5:48 PM and reported that she generally worked the night shift but on 11/07/22 she was working on the day shift to help the facility. Nurse #2 stated that she only recalled taking care of Resident #1 once or twice and she did not recall Nurse #1 reporting any STAT labs that Resident #1 required on 11/07/22. Nurse #2 stated that if she had been aware that Resident #1 had an order for STAT labs and a STAT chest Xray she would have drawn the labs and taken them to the local hospital for processing and ordered the chest Xray to be done at the facility. Nurse #2 stated "honestly I do not recall communicating with Nurse #1 that day at all."

The Director of Nursing (DON) was interviewed on 12/28/22 at 5:14 PM. She stated that the facility was responsible for obtaining their own labs and that when Nurse #1 received the order for the STAT labs and STAT chest Xray she should have carried those orders out and obtained them. The DON stated that both Nurse #1 and Nurse #2 were able to draw blood and there was no excuse why it was not done. She confirmed that Nurse #1 was the acting supervisor on 11/07/22 and she should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 658	Continued From page 4 ensured the orders were carried out and the chest Xray ordered as the MD had directed.	F 658		