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 _____	04/11/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 04/08/2019 through 04/11/2019. The facility was found in compliance with the requirement CFR 483.73,Emergency Preparedness. Event ID # 3W6B11.	E 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(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 record review and staff interviews, the facility failed to complete a significant change in status assessment (SCSA) Minimum Data Set (MDS) following admission into Hospice care for 1 of 1 resident reviewed for Hospice (Resident #48). Findings included: Resident #48 was originally admitted to the facility on 4/22/16 and readmitted on 7/31/16. The resident's diagnoses included, in part: hemiplegia and hemiparesis (weakness and paralysis of one side of the body), stroke, dementia, generalized	F 637	1. A significant change in status assessment (SCSA) will be scheduled and completed as required for resident #48 regarding admission to Hospice Care. 2. The Center Nurse Executive or Nurse Practice Educator audited Minimum Data Set(MDS)MDS's in progress on 05.01.19 to ensure a significant change in status assessment is completed for any resident that requires admission to Hospice Care and shown to be in compliance. 3. The Clinical Reimbursement Manager	5/3/19

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

Electronically Signed | 05/02/2019

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 _____	04/11/2019

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 637	Continued From page 1 weakness, lack of coordination, osteoarthritis, disorder of bone density and structure, seizures, anxiety, contracture of the left hand, osteoporosis, and contracture of the left elbow. Review of Resident #48's completed MDS assessments included a quarterly assessment dated 10/11/18, a SCSA dated 12/13/18 which had been completed and then inactivated (indicating the event did not occur), and another quarterly assessment dated 3/6/19. A progress note written by the facility Social Worker (SW) dated 11/27/18 at 10:39 AM revealed Resident #48 was admitted to Hospice care on 11/27/18 and the care plan was going to be updated. Review of Resident #48's care plan revealed a Hospice care plan with a start date of 11/27/18, initiated on 11/28/18, and most recently updated on 3/11/19. A physician's progress note dated 11/29/18 revealed Resident #48 had been placed on hospice and comfort care. Resident #48's most recent quarterly MDS dated 3/6/19 revealed Resident #48 had severe cognitive impairment. Resident #48 was also coded as having had a condition or chronic disease that may result in a life expectancy of less than 6 months and had received hospice services during the assessment period. An interview with the MDS Coordinator was conducted on 4/10/19 at 1:29 PM. She stated the significant change assessment for Resident #48 converting to Hospice was completed and then	F 637	(Regional MDS Nurse) reeducated the facility MDS nurse on completion of a significant change in status assessment for any resident that requires admission to Hospice care on 05.01.19. 4. The Center Nurse Executive or Nurse Practice Educator will audit 10% of weekly MDS's for significant change in status assessment for need of admission to Hospice Services prior to transmission for 2 months and then randomly thereafter to determine compliance. The Center Nurse Executive will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and 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 _____	04/11/2019

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 637	Continued From page 2	F 637		

she inactivated the significant change assessment. The MDS Coordinator stated the resident converted to Hospice on 11/27/18 and the significant change assessment had an ARD of 12/13/18. The MDS Coordinator stated she had inactivated the assessment because she had been told by corporate to inactivate the significant change assessment due to the resident having been on Hospice. The MDS Coordinator stated she had completed the inactivation of the significant change assessment on 1/23/19. The MDS Coordinator then stated the next assessment she completed for Resident #48 was a quarterly assessment with an ARD of 3/6/19. The MDS Coordinator further stated she usually did not do a significant change if a resident changed to hospice. The MDS Coordinator stated she would do a significant change assessment on a resident who had changes in two areas which have lasted or are going to last. The MDS Coordinator stated Resident #48 was receiving palliative or comfort care when she was placed on Hospice and so a significant change did not need to be completed. The MDS Coordinator stated there should not be more than 92 days between MDS assessments and she should have replaced the significant change with another assessment and it was an error on her part.

A second interview was conducted on 4/10/19 at 4:12 PM with the MDS Coordinator. The MDS Coordinator stated she had discussed the inactivation of the significant change for Resident #48 with her consultant. The MDS Coordinator stated a modification or correction should have been completed on the significant change assessment for Resident #48 and the significant change assessment should not have been

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 _____	04/11/2019

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 637	Continued From page 3 inactivated. An interview was conducted on 4/11/19 at 11:26 AM with the Administrator. The Administrator stated his expectation was for a significant change assessment to be completed on a resident after a resident was placed on hospice.	F 637		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations, the facility failed to accurately code a Minimum Data Set (MDS) for special treatments, procedures and programs while residing in the facility for 1 of 5 residents reviewed for MDS accuracy (Resident # 123). Findings included: Resident # 123 was admitted to the facility on 03/28/2019 with diagnoses that included pleural effusion, cerebral infarction (stroke) and empyema (the collection of pus in the lung cavity) and pneumonia. Resident # 123 had a care plan initiated on 03/28/2019 revealed that he exhibited or was at risk for respiratory complications related to pneumonia. The care plan goal was that Resident # 123 would have no signs or symptoms of respiratory distress through the next review. Interventions included to obtain laboratory tests as ordered, keep the head of the bed elevated at	F 641	1. Resident #123 Minimum Data Set(MDS) was modified by the MDS Coordinator to reflect accurate coding on 05.01.19. 2. The Center Nurse executive or designee began audit of Minimum Data Set (MDS's) in progress to ensure oxygen therapy or intravenous (IV) medications (MDS section O O0100 C and H) is accurately coded prior to being transmitted to the Minimum Data Set (MDS) database on 05/02/19. 3. The Clinical Reimbursement Manager (Regional MDS Nurse) reeducated the facility Minimum Data Set (MDS) nurse on the Resident Assessment Instrument (RAI) for Minimum Data Set (MDS) Section O O0100 C and H on 05.01.19. 4. The Center Nurse Executive or designee will audit 10% of weekly	5/3/19

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 _____	04/11/2019

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 641	Continued From page 4 30 degrees and observe for increased wheezing and decreased activity tolerance and report to the physician (MD). A review of another care plan for Resident # 123 dated 03/28/2019 included that Resident # 123 had a peripheral inserted central catheter (PICC) for IV antibiotic therapy and that Resident # 123 would remain free of complications related to IV therapy through the next review. Care plan interventions included in part to flush the PICC as per policy, inspect the PICC insertion site for inflammation or redness every shift (qs), to monitor for an allergic reaction to the IV medication, to monitor for signs or symptoms of complications such as pain, swelling or redness at the PICC insertion site, fever and drainage at the PICC insertion site. A review of an MD order dated 03/29/2019 revealed that Resident # 123 was to receive IV antibiotic therapy daily until 04/16/2019. Resident # 123 was also to receive oxygen at 2L (liters) via nasal cannula (NC) continuously. A review of a comprehensive MDS for Resident # 123 dated 04/04/2019 revealed that Resident # 123 had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs) and did not receive oxygen therapy or intravenous (IV) medications (MDS section O O0100 C and H) while a resident in the facility. An observation of Resident # 123 on 04/08/2019 at 2:25 PM revealed Resident # 123 was asleep in bed with nasal cannula at 2L in place and an IV antibiotic fluid connected to the PICC line in his right upper arm.	F 641	Minimum Data Set (MDS's) for section O O0100 C and H for accuracy prior to transmission weekly for 2 months. Then once a month for four (4) months thereafter to determine compliance. Center Nurse Executive will submit results of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and 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 _____	04/11/2019

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 641	Continued From page 5 An interview with nurse #2 conducted on 04/10/2019 at 10:23 AM revealed that Resident # 123 received a daily IV antibiotic that was infused through a right upper arm PICC line and to the best of her recollection the antibiotic had been ordered and administered since he was admitted on 03/28/2019 or the day after on 03/29/2019. Nurse #2 revealed that Resident # 123 also received oxygen therapy at all times because of his lung infections. On 04/10/2019 at 1:44 PM an interview was conducted with the MDS nurse. The MDS nurse reviewed the MDS dated 04/04/2019 for Resident # 123 and stated that she did not code the oxygen or the IV medication for Resident # 123 because it was an over site that she had made. On 04/10/2019 at 8:24 AM the facility administrator was interviewed and revealed that the expectation was that all MDSs be coded correctly prior to being transmitted to the MDS data base.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		5/3/19

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 _____	04/11/2019

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 656	Continued From page 6 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, hospice representative interview, and staff interviews, the facility failed to collaborate with hospice to develop and implement an interdisciplinary care plan for one of one resident reviewed for hospice (Resident #48). Findings included: Resident #48 was originally admitted to the facility	F 656	1. Resident #48 still resides in the facility under Hospice care. An Interdisciplinary care plan meeting was held on 05.02.19 with the patient representative, facility representatives, and Hospice representatives to review and collaborate resident's Plan of Care. 2. The Center Executive Director will audit	

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 _____	04/11/2019

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 656	Continued From page 7 on 4/22/16 and was most recently readmitted on 7/31/16. The resident's diagnoses included, in part: hemiplegia and hemiparesis (weakness and paralysis of one side of the body), stroke, dementia, generalized weakness, lack of coordination, osteoarthritis, disorder of bone density and structure, seizures, anxiety, contracture of the left hand, osteoporosis, and contracture of the left elbow. Review of Resident #48's most recently completed Minimum Data Set revealed a quarterly assessment with an Assessment Reference Date of 3/6/19. Review of the assessment revealed the following: The resident was coded as having had severe cognitive impairment. The resident was not coded as having had behaviors. The resident was coded as the following: Having required total assistance of 1-2 people for all Activities of Daily Living (ADLs), not having transferred (such as out of the bed to a chair or wheelchair) during the assessment period, having had a limitation in functional range of motion to one side of her upper extremity, having had a condition or chronic disease that may result in a life expectancy of less than 6 months, as having had received hospice services during the assessment period. A review of the Resident #48's medical record revealed a progress note dated 11/27/18 and timed 10:39 AM, written by the facility Social Worker (SW), which stated the resident was admitted to Hospice care on 11/27/18 and the SW was going to document Hospice services in the Care Plan. Review of the resident's care plan which had	F 656	residents currently being followed by Hospice Services to ensure facility is collaborating with Hospice Agency to develop and implement an interdisciplinary plan of care and ensure invitation is sent to Hospice representative for attendance to Care Plan meeting. 3. The Center Executive Director reeducated the center Social Services Director on inviting Hospice representative to Care Plan meetings to ensure collaboration with resident Plan of Care. The Center Executive Director had conversation with Hospice CEO and reviewed Hospice Service Agreement with emphasis on Development and Implementation of Plan of Care and that going forward the center Social Services Director will invite Hospice representative(s) to facility Care Plan meeting, when a resident is under the care of Hospice agency to ensure collaboration of resident plan of care. 4. The facility Center Executive Director will audit all residents under Hospice Care monthly for 3 months to ensure collaboration with Hospice Agency with the resident care plan and that an invitation has been extended to the Hospice Agency as appropriate for resident Plan of Care meeting. The Center Executive Director will submit results of audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and need for ongoing monitoring.	

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 _____	04/11/2019

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 656	Continued From page 8 been most recently revised on 3/11/19 revealed a Hospice care plan with a Hospice start date of 11/27/18 and a care plan initiation date of 11/28/18. Review of the physician's progress notes for Resident #48 revealed a progress note dated 11/29/18 which documented the resident was on hospice and comfort care. An interview was conducted with the facility Social Worker (SW) on 4/10/19 at 3:08 PM. The SW stated Hospice comes in and does personal care, medication review, and medication management for Resident #48. The SW stated the Hospice Social Worker had met and continues to meet with the family to discuss end of life care. The SW stated the resident's family member as invited to the resident's care plan meetings. The SW stated she was the person who invited individuals to the care plan meetings. She stated she was not aware if Hospice reviewed or coordinated anything on the facility care plan. The SW stated she was not aware if the facility reviewed or participated in any part of the Hospice care plan. A phone interview was conducted on 4/11/19 at 10:27 AM with the Hospice Registered Nurse (RN). The RN stated their Plan of Care (POC) was in Resident #48's chart. She stated the hospice staff communicated with the facility staff regarding the coordination of care regarding Resident #48. An interview was conducted with the facility SW on 4/10/19 at 3:08 PM. SW stated she was aware Hospice had placed their own POC on the chart for Resident #48 but the Hospice POC was	F 656	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 _____	04/11/2019

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 656	Continued From page 9 not coordinated with the facility care plan. An interview was conducted on 4/11/19 at 11:26 AM with the Administrator. The Administrator stated it was his expectation to coordinate Hospice Plans of Care with the facility Care Plan.	F 656		
F 689 SS=G	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 record review and staff interviews, the facility failed to use a sling lift for transfer to prevent a fracture of the left humerus (upper arm) for one of two residents reviewed for accidents, Resident #48. Instead the resident was transferred via a stand pivot sit transfer with the assistance of one agency staff nursing assistant. The findings included: Resident #48 was originally admitted to the facility on 4/22/16 and was most recently readmitted on 7/31/16. The resident's diagnoses included, in part: hemiplegia and hemiparesis (weakness and paralysis of one side of the body), stroke, dementia, generalized weakness, lack of coordination, osteoarthritis, disorder of bone density and structure, seizures, anxiety, contracture of the left hand, osteoporosis, and	F 689	1. Resident #48 continues to require a sling lift for all transfers and currently resides in the facility. 2. A lift, transfer and reposition assessment audit was completed by the Center Nurse Executive and staff scheduler on 04.30.19. All residents lift, transfer and reposition audits were shown to be in compliance according to their assessments. 3. The Nurse Practice Educator reeducated all nursing staff regarding safe resident handling, resident transfer key and safe resident transfers on 05.03.19. A lift/transfer audit will be completed weekly by the Center Nurse Executive or designee to ensure residents current	5/3/19

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 _____	04/11/2019

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 contracture of the left elbow. Review of Resident #48's Minimum Data Set (MDS) completed prior to revealed a quarterly assessment with an Assessment Reference Date (ARD) of 10/11/18. Review of the assessment revealed the following: The resident was coded as having had severe cognitive impairment. The resident was not coded as having had behaviors. The resident was coded as having required total assistance of 1-2 people for all Activities of Daily Living (ADLs) including transfers, such as from the bed to a wheelchair. The resident was coded as having had a limitation in functional range of motion to one side of her upper extremity. A review was completed of a document titled Lift Transfer Reposition-V2, dated 11/8/18, signed by the Director of Nursing (DON), and timed 10:15 AM for Resident #48. The resident was documented as unable to transfer without a device, unable to bear weight equal to or greater than 50% of her weight and required a total lift or sling lift. Review of a Progress Note, written by the DON, with an effective date of 11/8/18 and timed 10:15 AM revealed a lift evaluation of Resident #48 had been completed. The evaluation revealed the lift type for the resident was a total lift or sling lift. Review of Resident #48's Progress Notes revealed an entry dated 11/18/18 and timed 11:00 am by Nurse #1. The note documented the resident had a bruise to her left upper extremity (left arm), with no pain noted, and the resident was documented as having had agitation with ADLs and transfers.	F 689	transfer needs are in compliance, the audit began on 04.30.19. 4. The Center Nurse Executive or Nurse Practice Educator will conduct three (3) random audits per week for (4) four weeks, then randomly thereafter on proper transfer mode for residents with the Transfer audit tool. The Center Nurse Executive will submit results to the monthly Quality Assurance Performance Improvement Committee meeting for review and 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 _____	04/11/2019

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		

Review of a facility investigation report dated 11/21/18, and signed off by the Administrator, revealed an investigation regarding the Injury of Unknown Origin (IUO), the left upper arm fracture, for Resident #48. Review of the summary of the facility investigation revealed Nursing Assistant (NA) #2 had reported transferring Resident #48 independently without using the sling lift after having been misinformed of the resident's transfer status. The report stated the transfer conducted by NA #2 had caused bruising to the left upper arm and subsequent fracture of the same arm. Further review of the submission report revealed a written statement by NA #2 in which she wrote on 11/17/18 she had transferred Resident #48 with a one person assistance, without using the sling lift, after having been told by facility staff that Resident #48 needed one person assistance for transferring, such as into and out of bed and to or from a wheelchair. The NA further wrote the resident had complained of pain with repositioning after the transfer and when she had other staff assist her in returning the resident to bed. The NA also wrote she was assigned to provide care for the resident on 11/18/18 and the resident had continued to complain of pain the following day. The NA wrote she had discovered bruising to the resident's left upper arm and had reported the bruising and the resident's complaints of pain to Nurse #1.

An interview was conducted on 4/10/19 at 11:17 AM with Nurse #1. The nurse stated she remembered when it had been reported to her that Resident #48 had an injured left arm, it was on Sunday 11/18/18. The nurse stated when they went to turn the resident on 11/18/18, the resident was screaming, and the resident had a bruise 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 _____	04/11/2019

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		

her left shoulder. The nurse stated the bruise was approximately the size of a softball and was yellowish in color. She stated when she had asked staff, including NA#2, about the bruise they stated it had been the first time they had seen the bruise. The nurse stated she had informed the resident's responsible party, contacted the physician, and had ordered an X-Ray of the left shoulder.

Review was conducted of an X-Ray report for Resident #48 with a date of service of 11/19/18. The results of the X-Ray were there was an acute (sudden or recent) left humerus (upper arm) fracture. In addition, the X-Ray report documented the resident's bones appeared diffusely demineralized (a lack of minerals which provide bone strength such as calcium).

Review of a Diagnostic Imaging report for Resident #48 with an exam date of 11/20/18 revealed a left shoulder X-Ray had been completed. The listed indications for the X-Ray included: left shoulder pain and left shoulder bruising. The conclusion of the X-Ray was there was an acute fracture of the left upper arm, the bones were observed to have been extremely osteopenic (bone and mineral loss causing bones to lose strength to protect against fracture) with a somewhat "moth-eaten" appearance. The conclusion further stated the appearance could have represented a blood dyscrasia (an abnormal or disordered state of a body part) or multiple myeloma (a malignant (cancerous) tumor).

An interview was conducted on 4/10/19 at 2:38 PM with the Staffing Coordinator (SC). She stated there was a symbol outside of the resident's door which indicated the type of

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 _____	04/11/2019

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		

transfer a resident required and she stated the information was also available in NA information book available at each nurses' station. She stated Resident #48 was not a one person assistance transfer in November 2018 when her arm was fractured, the resident was a sling lift or total lift. The SC stated she and one other staff member did most of the updating of the NA information book. The SC stated there was further information available about the residents in the NA information book, information such as transfers and toileting. The SC stated as part of the orientation process for agency NAs, they were trained on how to check the NA information book, codes on the doors, and the facility equipment for transfers. She stated NA #2 was an agency NA and she would have been trained on referring to the NA information book at the time of her orientation. The door coding was put into place after NA #2 had completed her orientation.

An interview was conducted on 4/10/19 at 3:31 PM with the Nurse Practice Educator (NPE). She stated a new practice to assist staff in being aware of the type of transfer a resident required through the use of a code on the resident's door and all staff had the key for the codes on a card affixed to their name tags. She stated the practice was put into place near the end of 2018. The NPE stated in addition to the code system, if a resident was a total or sling lift transfer, their names were on a list in the NA information book at each nurses' station. The NPE stated Resident #48 had been a total or sling lift transfer for a long time. The NPE stated it was her expectation for a NA to refer to the resources available to verify the appropriate transfer and equipment and to utilize the required equipment to safely transfer the resident.

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 _____	04/11/2019

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 An interview was conducted on 4/11/19 at 11:26 AM with the Administrator. The Administrator stated his expectation was for residents to be transferred safely and to be transferred utilizing the correct transfer equipment per the resident's transfer evaluation.	F 689		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(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 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842		5/3/19

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 _____	04/11/2019

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 842	Continued From page 15 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (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 record review and staff interviews the facility failed to record bowel movements for 2 of	F 842	1. Resident #37 still resides in the facility and documentation is completed daily 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 _____	04/11/2019

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 842	Continued From page 16	F 842		

2 residents on the form titled Activity of Daily Living (ADL) Record (Resident #37 and Resident #121). The facility failed to document an order, record an order correctly, and document wound care after an injury for one of three residents reviewed for accuracy of medical record (Resident #39).

Findings included:

1. Resident #37 was admitted to the facility on 1/18/18 with diagnoses of Parkinson's Disease, Heart Failure, and Osteoarthritis.

A review of Resident #37's most recent Minimum Data Set Assessment dated 1/16/19 revealed she did not require assistance with toileting. The assessment further revealed Resident #37 was occasionally incontinent of bladder and always incontinent of bowel, and she was on a toileting program. Resident #37 was also noted to be severely cognitively impaired.

The Continence Management Policy dated 1/23/18 revealed daily toileting activity should be recorded on the Activity of Daily Living Record.

A Care Plan dated 2/13/19 revealed Resident #37 required assistance with toileting and had episodes of delusional thinking. The Care Plan further revealed Resident #37 would have episodes of believing she had been incontinent but she was not soiled.
The February 2019 Bowel and Bladder Toileting Schedule revealed Resident #37 was not assisted with scheduled toileting as indicated on February 25 and 27, 2019. A review of the March 2019 Bowel and Bladder Toileting Schedule was reviewed and Resident #37 was not assisted with

record bowel movements on the form Activity of Daily Living Record. Resident #121 is no longer at the facility. Resident #39 still resides in the facility and the skin tear has been healed to the left shin.

2. An audit of the Activity of Daily Living (ADL) flowbooks was completed by the Nurse Practice Educator or designee to ensure completion of documentation in the Activity of Daily Living record of bowel movement on 05.01.19, of the April 2019 Activities of Daily Living notebook. An audit of current wound treatment orders to ensure proper documentation of the order and recording of the order correctly and documentation of wound care was completed by the Center Nurse Executive on 05.01.19.

3. The Nurse Practice Educator or designee reeducated nursing staff on proper documentation and completion of Activity of Daily Living records. The Nurse Practice Educator reeducated licensed nurses on entering wound treatment orders accurately and timely following an incident with appropriate follow up documentation.

4. Daily audits will be conducted Monday through Friday of the Activity of Daily Living records by the interdisciplinary team to ensure accuracy and completion of records, for three (3) months. The Center Nurse Executive will report findings of the audits to the monthly Quality Assurance and Performance Committee meeting for review and need

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 _____	04/11/2019

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 842	Continued From page 17 scheduled toileting as indicated on March 1, 5, 8, 11, 15, 16, 17, 18, 21, 22, 26, 27, and 28, 2019. The April 2019 Bowel and Bladder Toileting Schedule revealed Resident #37 was not assisted with scheduled toileting on April 1, 2, 4, 5, 6, 7, 9, and 10, 2019. On 4/9/19 at 11:33 am during an observation of Resident #37 she was up in her room in her wheelchair. She rolled her wheelchair around in her room and out into the hallway. She spoke with visitors as they passed her room. She did not attempt to get up unassisted and did not attempt to go to the bathroom unassisted during the observation. An interview with Nurse Aide #1 on 4/9/19 at 11:40 am revealed Resident #37 would attempt to take herself to the bathroom unattended. Nurse Aide #1 stated she would offer to take Resident #37 to the bathroom every 2 hours but sometimes she would have already have taken herself without assistance. An observation on 4/9/19 at 4:15 pm revealed Resident #37 was up in her wheelchair in her room. She moved about in her room and did not attempt to get up unassisted or go to the bathroom unassisted. During an interview with Nurse #1 on 4/10/19 at 2:11 pm she stated Resident #37 had been on a scheduled toileting program since January 2018. Nurse #1 stated she was aware the scheduled toileting had not been completed by the Nurse Aides (NAs) on several occasions as evidenced by the missed documentation on the February, March, and April 2019 Scheduled Toileting Forms.	F 842	for ongoing monitoring. Daily audits will be conducted Monday through Friday of treatment orders and timely and appropriate documentation, for three (3) months. The Center Nurse Executive will report findings of the audits to the monthly Quality Assurance Performance Improvement Committee meeting for review and 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 _____	04/11/2019

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 842	Continued From page 18	F 842		

Nurse #1 stated she did not know why the NAs had not assisted Resident #37 with the Scheduled Toileting Program as required but an in-service education would be given for the for following the Scheduled Toileting Program.

An interview with the Administrator on 4/11/19 at 10:27 AM revealed he was not aware the nursing staff had not assisted Resident #37 with Scheduled Toileting. The Administrator stated his expectation was that all nursing staff would follow the protocol and document appropriately if a scheduled toileting program was initiated for any resident.

2. Resident # 121 was admitted to the facility on 04/05/2019 with diagnoses that included cervical spine fusion, chronic pain and a history of constipation.

A review of Resident # 121's medical record revealed that a comprehensive MDS was in progress.

A review of care plans for Resident # 121 revealed that baseline care plans were initiated for Resident # 121 on 04/05/2019 but did not include a care plan related to constipation.

A review of a medication administration record (MAR) for Resident # 121 dated 04/07/2019 revealed that Resident # 121 received an enema on 04/07/2019 and that the enema was effective.

On 04/10/2019 at 10:01 AM a review of a form titled ADL (Activity of Daily Living) RECORD revealed that resident bowel movements were to be recorded on night, day and evening shifts with

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 _____	04/11/2019

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 842	Continued From page 19	F 842		

codes to document if the resident was continent or incontinent, bowel movement (BM) consistency, BM size and the number of BMs on each shift. Resident # 121 was recorded as being continent of one medium BM on the evening shift of 04/05/2019. On 04/06/2019 Resident # 121 was coded as continent of BM on the day shift, on 04/07/2019 the form was not coded in any areas for 3 shifts. On 04/08/2019 through 04/10/2019 Resident # 121 was coded as continent of BM. The ADL record was blank in the other areas for BM coding from 04/05/2019 through 04/10/2018. The form was not initialed by a staff member on the day shifts on 04/07/2019 or 04/09/2019 and the evening shift on 04/07/2019.

On 04/10/2019 at 10:21 AM nurse assistant (NA) # 2 was interviewed.NA # 2 revealed that the ADL Record form was to be completed and initialed by NAs on each shift. NA # 2 revealed that she could not explain why the form for Resident # 121 was not completed as directed.

Nurse # 2 was interviewed on 04/10/2019 at 10:23 AM. Nurse # 2 confirmed that the form titled ADL Record was to be completed by NAs by the end of the three shifts and that the licensed nurses were responsible to review the ADL Record form by the end of each shift and if the form was not completed the nurse was to have the NA complete the form before the end of the shift. Nurse # 2 revealed that she did not review the form at the end of her shift and was not aware of the blanks on the form for Resident # 121. Nurse # 2 revealed that she understood part of her duties was to check the ADL Record and she did not check the form as she had been directed 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 _____	04/11/2019

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 842	Continued From page 20	F 842		

An interview conducted with nurse # 1 on 04/11/2019 at 8:43 AM revealed that NAs were to complete the ADL Record form by the end of each shift and the licensed nurses were to check the ADL Record form at the end of each shift to make certain the form was completed by the NAs and if not, the nurses were to notify the NAs to complete the form before they left at the end of their shift. Nurse #1 confirmed that the ADL Record had no place for the nurse to sign or initial that the form was checked for completion. Nurse #1 revealed that the expectation was that the form be completed at the end of each shift and that there were no blanks on the form.

The facility administrator was interviewed on 04/11/2019 at 9:46 AM. The administrator revealed that the expectation was that all ADL Records be completed by all nursing staff and reviewed at the end of each shift to be certain that there were no blanks or missed documentation on the forms.

3. Resident #39 was admitted to the facility on 2/19/18. The resident's cumulative diagnoses included, in part: Congestive Heart Failure (CHF), generalized weakness, rheumatoid arthritis, osteoporosis, scoliosis, lack of coordination, and abnormalities of gait and mobility.

Review of Resident #39's most recently completed Minimum Data Set (MDS) revealed an annual comprehensive assessment with an Assessment Reference Date (ARD) of 2/20/19. Review of the assessment revealed the following: The resident was coded as having had mild cognitive impairment. The resident was coded as having required extensive to total assistance of 1-2 people for all Activities of Daily Living (ADLs) except for eating where she was coded as having

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 _____	04/11/2019

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 842	Continued From page 21	F 842		

required supervision of one person. The resident was coded as not having transferred (such as out of the bed to a chair or wheelchair) during the assessment period. The resident was coded as having had a limitation in functional range of motion to both sides of her upper and lower extremities. The resident was coded as having had none of the following: pressure ulcers, venous or arterial ulcers, other ulcers, wounds or skin problems.

A review was completed of a Risk Management System (RMS) incident report for Resident #39 for an event dated 3/27/19 and timed 10:00 AM. The report documented the resident was transferring from the bed to the chair with staff assistance, and her left leg gave out and went underneath the chair and the resident sustained a skin tear to the left shin. The report was completed by Nurse #3. The description of the immediate actions taken was treatment to skin tear applied. First aid, consisting of ointment and border gauze, was administered as having been applied by Nurse #3 and the Treatment Nurse.

Review of Resident #39's Treatment Administration Record (TAR) for the month of March 2019 revealed no record of a treatment applied to a skin tear or a treatment to the resident's left leg.

Review of Resident #39's Progress Notes from 3/25/19 through 4/8/19 revealed no documentation of the application of a treatment applied to a skin tear or to the resident's left leg. There was mention of a skin tear to the resident's leg dated 4/1/19 and 4/8/19, but no type of treatment was mentioned.

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 _____	04/11/2019

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 842	Continued From page 22	F 842		

Review of the physician's orders for Resident #39 revealed the resident had an order dated 4/2/19. The order read, Clean skin tear on left lower leg with soap, pat dry, apply collagen dressing, and cover with a foam dressing every day until healed.

Review of the April TAR for Resident #39 revealed the resident had an order with a start date of 4/4/19 and read, clean skin tear on left lower leg with soap, pat dry, apply collagen dressing, and cover with foam dressing every day until healed, every evening shift, every 2 days, for skin tear. The treatment was not signed off as administered or applied on 4/2/19 as evidenced by the presence of an "X" for that date. The treatment was signed off as administered on 4/4/19, 4/6/19, and 4/8/19. The dates the treatment could not be administered on the TAR were blocked with an "X" from 4/3/19 through every other day through the end of the month.

An interview was conducted on 4/10/19 at 9:50 AM with the Nurse Practice Educator (NPE). The NPE stated the order was for the treatment to have been applied daily but the scheduling details which had been entered into the system was in the system as every 2 days. She stated the order and the treatment schedule on the TAR were confusing. The confusion was due to the order having read to do the dressing change daily and the scheduling of the treatment was entered as every 2 days. The NPE reviewed the resident's hard chart and there were no written orders for the treatment. The NPE reviewed another book at the nurses' station which contained printouts of the physician's orders and there was not a printout of the order. The NPE stated she believed the Treatment Nurse had entered 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 _____	04/11/2019

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 842	Continued From page 23	F 842		

order directly into the Electronic Medical Record.

A phone interview was conducted on 4/10/19 at 10:09 with the Treatment Nurse (TN). The TN stated she had meant to write the order as every other day, the way she had entered it into the TAR, but she had written the order as every day. The TN stated it was an error in how she had entered the order, but the treatment was being applied as the original intent of how she had originally intended to have been applied, every other day. The TN stated she had transcribed the order as to the original intent of the order into the TAR. The TN stated she had remembered applying the treatment the day she had written the order, 4/2/19.

An interview was conducted on 4/9/19 at 11:36 AM with Nurse #3. Nurse #3 stated she completed the RMS incident report for Resident #3 on 3/27/19. The nurse stated she consulted with the TN after the incident for a treatment to the skin tear. The nurse stated she and the TN went into the resident's room together, she cleaned the wound, the TN had applied the treatment and the dressing to the wound on the resident's left leg. The nurse stated she should have documented the wound care and the wound in the nurses' notes, but she put the wound care and the treatment in the incident report. The nurse was unable to find the order for the treatment applied to the resident and stated she had thought the TN entered the order for the treatment. The nurse stated there was an order on 4/2/19 but there were no orders for the treatment to the resident's leg prior to that order. The nurse was also unable to locate the treatment in the March 2019 when she reviewed the TAR.

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 _____	04/11/2019

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 842	Continued From page 24 During an interview with the NPE on 4/10/19 at 3:31 PM she stated it was her expectation for an order to be written for a treatment and dressing applied to a resident. The NPE further stated it was her expectation for there to have been follow through such as documentation in the progress notes regarding the status of a wound and the treatment being applied. The NPE stated it was her expectation for physicians' orders to match the scheduling portion of the order. An interview was conducted on 4/11/19 at 11:26 AM with the Administrator. The Administrator stated his expectation for orders to be written for a treatment, there to be documentation regarding the treatment, and follow up regarding treatments which have been applied. The Administrator further stated it was his expectation for the physician's order and the scheduled treatment to match.	F 842		