STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGE CARE OF KING	440 INGRAM ROAD KING, NC 27021

(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 02/07/2022 to 02/10/2022. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID #UQKG11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation surey was conducted on 02/07/2022 to 02/10/2022. 1 of 1 complaint allegation was unsubstantiated. Event ID #UQKG11.	F 000		
F 584 SS=B	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §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. 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 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		3/11/22

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

Electronically Signed | 03/04/2022

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain walls in good repair for 5 of 15 rooms (Rooms 305D, 307D, 308W, 309D and 315D) on the 300 hall reviewed for environment. Findings included: 1a. Observations of room 305D on 2/7/22 at 2:00 PM and 2/10/22 at 10:53 AM revealed scuff marks in the wall behind the resident's bed. Part of the wall behind the bed had been patched but not painted. 1b. Observations of room 307D on 2/7/22 at 2:01 PM and 2/10/22 at 10:54 AM revealed a hole in the wall behind the resident's bed and sheet rock was exposed. 1c. Observations of room 308W on 2/7/22 at 2:02 PM and 2/10/22 at 10:55 AM revealed	F 584	*The wall behind the bed in room 305 D was repaired for visible damage and painted. The wall behind the bed in room 307 D was repaired for a hole in the wall that exposed the sheet rock. The wall behind the bed in 308 W was repaired for visible damages. The wall behind the bed in in 309 D was repaired for visible damages. The wall behind the bed in 315 D was painted. The repairs were done between February 14- March 1, 2022 by the Maintenance Director. * The Administrator conducted an audit of all the residents' rooms on February 14, 2022 to identify other wall integrity issues. A list of rooms that were in need in need of wall repair was then given to the Maintenance Director to ensure proper repairs	

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F 584	Continued From page 2 gouges in the wall behind the resident's bed. 1d. Observations of room 309D on 2/7/22 at 2:03 PM and 2/10/22 at 10:56 AM revealed a gouge in the wall behind the resident's bed. 1e. Observations of room 315D on 2/7/22 at 2:04 PM and 2/10/22 at 10:57 AM revealed the wall behind the resident's bed had been patched but not painted. During an interview with the Maintenance Director on 2/10/22 at 10:36 AM he stated facility staff notified him of repairs that were needed in residents' rooms. He said he had not routinely audited resident rooms for areas that needed repairs. He explained there was a work order box at the nurse's station that he checked two to three times a day. Staff filled out work order forms and placed them in the box. The Maintenance Director shared he had not kept notes of work that needed to be completed or of repairs that needed to be done. Rooms 305D, 307D, 308W, 309D and 315D were observed with the Maintenance Director on 2/10/22 from 12:58 PM-1:10 PM during which he verified the scuff marks, gouges and hole in the walls, along with the walls that had been patched but not painted. He said the scuffs and gouges in the walls were from the bed being pushed up against the wall in order for wheelchairs to get through since the rooms were small. He measured the hole in room 307 to be three inches by five inches. The Maintenance Director said he was not sure how long the scuff marks, gouges and hole in the walls had been there. He added he did not know how long the walls had been patched but not painted. He stated staff	F 584	are done. The repair work is in progress and will be completed by March 11, 2022 by the Maintenance Director. * The Maintenance Director and Maintenance Assitant were reeducated by the Administrator on the residents' right to have a safe, clean, comfortable, and homelike environment. This was completed on February 24, 2022. All staff were reeducated on our work order system so that repairs to walls can be done timely. This education was completed by the Administrator and the Nurse Unit Manager during February 24-March 10, 2022. * Audits of walls will be done in five random resident rooms by the Administrator/designee. This will be done weekly for three weeks and monthly for three months. Administrator will also audit three work orders at random per week for three weeks and then monthly for three months to ensure timely completition of the request. Auditing will begin the week of March 14, 2022. Results of these audits will be taken to the Quality Improvement Committee for further recommendations.	

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F 584	Continued From page 3 had not alerted him to any of the issues nor had they completed work orders. Interviews were completed with the Administrator on 2/10/22 at 10:13 AM and 1:23 PM. She stated the maintenance department was responsible to repair walls in the resident rooms. She and the Admissions Director looked at rooms routinely and identified areas that needed repair. The Administrator added that the Maintenance Director also completed room audits. The department managers completed rounds on resident rooms daily, identified environmental issues and discussed findings in their morning meetings with department manager staff. The Administrator shared she gave a list to the Maintenance Director each week of areas that needed to be repaired or addressed. When a resident moved out of a room the facility had worked on identifying issues in the vacated room and made repairs.	F 584		
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 staff interviews and record review, the facility failed to accurately code Special Treatments and Programs on the Minimum Data Set (MDS) assessment for 1 of 23 residents (Resident #10) reviewed for MDS accuracy. Findings included: Resident #10 was admitted to the facility on	F 641	* MDS for Resident #10 inaccurately coded was immediately modified with correct information during survey and transmitted to the state. *MDS coordinators reviewed and received reeducation on Section O coding of the MDS 3.0 RAI Manualv1.17_October 2019	3/11/22

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F 641	Continued From page 4 8/29/17. Diagnoses included, in part, hypertension and diabetes. The quarterly MDS assessment dated 11/23/21 specified Resident #10 received tracheostomy care, was on a mechanical ventilator, and received dialysis and Hospice services during the 14 day lookback period. Resident #10's medical record was reviewed and revealed the resident did not have a tracheostomy and had not been on a ventilator. Further review indicated Resident #10 was not on dialysis or Hospice services. During an interview with MDS Nurse #1 on 2/10/22 at 9:09 AM, she reported she completed Resident #10's quarterly MDS assessment. She explained when she coded the special treatments and programs section, she reviewed the medical record and identified any special treatments, programs or procedures the resident received at the facility. She stated Resident #10 did not have a tracheostomy, was not on a ventilator and had not received dialysis or Hospice services. MDS Nurse #1 thought she probably clicked on the incorrect column when she went through the list of special treatments and services on the assessment. She added she would immediately complete a modification MDS assessment to correct her error. On 2/10/22 at 1:36 PM an interview was completed with the Administrator. She confirmed Resident #10 had not received tracheostomy care, ventilator, dialysis or Hospice services at the facility. She added the corporate office periodically reviewed MDS assessments for accuracy and provided education to staff as	F 641	concerning appropriate coding on March 1, 2022. *All MDS Assessments with the date of January 1, 2022 and later with Special Care and Extensive Services were audited to ensure the assessment was accurately coded in MDS Section O. The audit was completed on March 3, 2022. *Effective 3/1/2022, MDS Coordinators will perform cross check audit of any Special Care or Extensive Services prior to transmission of assessment for accuracy of Section O coding. * MDS will report findings audit/monitoring to the Administrator weekly for 12 weeks. *MDS will report the findings of the audit/ monitoring to the monthly QAPI Committee for review and recommendations concerning the plan and duration of monitoring time frame. MDS is responsible for implementing the acceptable plan of correction.	

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F 641	Continued From page 5 needed.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under	F 645		3/11/22

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F 645	Continued From page 6 paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit information for Preadmission Screening and Resident Review (PASSR) for a level 2 re-evaluation for 1 of 2 residents reviewed for PASSR (Resident #41). The findings included:	F 645	* Social Worker submitted information for a Preadmission Screening and Resident Review (PASSR)re-evaluation for Resident #41 on 2/10/2022. A new PASSR for resident #41 was received on 2/18/2022.Resident	

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F 645	Continued From page 7 The facility admitted Resident #41 to the facility on 06/28/2017 with diagnoses of, in part, anxiety and depression. An annual Minimum Data Set assessment dated 06/21/2021 revealed no review for a Level 2 PASRR. A review of a hospital history and physical dated 12/6/2020 indicated Resident #41 had a diagnosis of schizophrenia listed, dated 10/04/2017. A quarterly Minimum Data Set dated 12/22/2021 revealed Resident #41 received antipsychotic medication 7 out of 7 days of the look back period. A review of the care plan revealed a focus area of risk for altered behaviors and/or mood related to diagnosis of schizophrenia. Behaviors included episodes of medication and treatment refusals, periods of hallucinating, increased confusion, misplacing items, urinating on self or floor when displeased with new roommates, will site naked in wheelchair in full view of roommate/hallway. On 02/10/2022 at 11:15 AM, an interview was conducted with the facility ' s Social Worker who stated Resident #41 was initially admitted to the facility on 02/10/2016, discharged home and was readmitted on 03/10/2017. The resident was diagnosed with Schizophrenia in October of 2017 and at that time, there was another Social Worker at the facility, and she did not submit the application for a level 2 PASSR after the diagnosis was added. The Social Worker stated the application should have been submitted.	F 645	was determined to be a Level II. * Facility completed an audit of current residents PASSRS to ensure that any resident with a new mental health diagnosis(s) were identified on the current PASSR screen by 3/11/2022. Those residents identified that did not have an accurate PASSR evaluation on file was resubmitted for a new PASSR screening re- evaluation. * Administrator provided education to the social worker and the Admissions Director on the requirements of the PASSR processing for mental disorders and individuals with intellectual disabilities on 2/24/2022. * The Social Worker and Admission Director will audit each residents PASSR screen at the time of admission and quarterly thereafter for six months. Auditing will begin the week of 3/14/2022. The Social Worker/designee will report the results of the audits in the QAPI Meetings to ensure compliance, and/or need for modifications.	

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		3/11/22

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F 756	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Medication Regimen Review (MRR) was conducted monthly for 1 of 5 residents (Resident #230) reviewed for unnecessary medications. The findings included: Resident #230 was admitted to the facility on 12/30/2021 with diagnoses to include hypothyroidism, dementia with behavioral disturbance, right humerus fracture and atherosclerotic heart disease. An admission Minimum Data Set assessment dated 01/06/2022 revealed Resident #230 had severely impaired cognition and had behaviors of care rejection 1-3 days of the look back period. Resident #230 received antipsychotic, antianxiety, antidepressant and opiod medications during the assessments look back period. A pharmacy consultation summary report for the period of 01/02/2022 through 01/04/2022 did not indicate a MRR was conducted for Resident #230. A comprehensive medical record review did not include a MRR for January 2022 for Resident #230. An interview was attempted with the facility ' s Pharmacy Consultant on 02/10/2022 at 12:45 PM and on 02/10/2022 at 1:44 PM. Messages were left with no return call by the end of the survey. On 02/10/2022 at 1:55 PM, the pharmacy was	F 756	* Resident had MRR completed on February 2, 2022. * An Audit of all residents MRR was completed on 3/1/2020 by the facility's Consultant Pharmacist to identify any other concerns. No concerns were identified. *An audit of three residents scheduled to have an MRR will be completed weekly one time a week for three weeks and monthly for three months by the Administrator/designee. Results of these audits will be taken to the QAPI Committee for review and further recommendations for three months.	

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F 756	Continued From page 10 called, and a message left for the pharmacy consultant to return the call; no return call was received by the end of the survey. On 02/10/2022 at 3:30 PM, the concern regarding a MRR not conducted in January 2022 was brought to the attention of the Director of Nursing and the Corporate Nurse Consultant. The Corporate Nurse Consultant stated she believed the MRR for January 2022 was not conducted because Resident #230 was admitted on 12/30/2021.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to have a less than 5 percent medication rate as evidenced by 2 medication errors out of 25 medication opportunities, resulting in a medication error rate of 8 percent for 2 of 5 residents (Resident #30 and Resident #6) observed during medication pass. The findings included: 1. On 02/09/2022 at 3:10 PM, Nurse #1 was observed as she prepared and administered medications to Resident #20. The medication included one 2.5 milligram tablet of Eliquis (an anti-coagulant). While Nurse #2 attempted to pop	F 759	* Resident #20's physician was notified of medication omission. Physician did not give any new orders for Resident # 20. Resident # 20 did not have any adverse reactions noted. * Resident #6's physician was notified of medication error. Physician did not give any new orders for Resident #6. Resident #6 did not have any adverse reactions noted. * Nurse # 1 and Nurse # 2 received individual counseling and re-inservicing on the five	3/11/22

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F 759	Continued From page 11 the tablet from the punch card into the medication cup, the Eliquis tablet was observed to land on a binder that was on top of the medication cart and not in the medication cup. Nurse #1 continued into Resident #30 ' s room with the medication cup that did not include the residents Eliquis. A continuous observation on 02/09/2022 from 3:10 PM to 3:20 PM revealed Nurse #1 signed off on Resident #30 ' s medication administration record that the Eliquis was administered than continued to administer medications to Resident #21 and Resident #29 and the 2.5 milligram tablet of Eliquis remained on top of the medication cart. On 02/09/2022 at 3:22 PM, an interview was conducted with Nurse #1 when the state surveyor directed her to the tablet on top of the medication cart. Nurse #1 stated she did not know who that belonged to. The state surveyor informed Nurse #1 the tablet was Resident #30 ' s 2.5 milligrams of Eliquis that did not go into the medication cup. Nurse #1 stated she did not notice that the tablet had dropped and did not go into the medication cup. On 02/09/2022 at 3:30 PM, the Director of Nursing, Assistant Director of Nursing and Corporate Nurse Consultant were notified of the medication error. 2. Resident #6 was admitted to the facility on 01/09/2020 with a cumulative diagnosis which included chronic obstructive pulmonary disease. A review of Resident #6 ' s active physician ' s orders included a current order for 160 microgram/4.5 microgram Symbicort to be administered as two puffs twice a day initiated on 10/12/2021. Symbicort is an inhaled medication	F 759	rights of medication administration. * Effective 3/11/2022 100% of licensed nurses and medication aides were in-serviced on the five rights of medication administration. The education was provided by Administrator and the Nurse Unit Manager. * Effective the week of 3/14/2022 medication administration will be observed by the Director of Nursing/designee, Nurse Unit Manager, and/or Pharmacy Consultant. Observation audits will consist of ensuring medications are being administered as ordered. Audits will be completed by observing a total of three nurses or medications aides three times a week for four weeks, weekly for four weeks, and then monthly for 3 months. Results of these audits will be reviewed in the QAPI Committee to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345381	A. BUILDING _____ B. WING _____	C 02/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 759	Continued From page 12 containing a combination of two medications, budesonide (a steroid) and formoterol. It is used for the management of asthma and/or chronic obstructive pulmonary disease. On 02/10/2022 at 8:30 AM, Nurse #2 was observed as she prepared and administered medications to Resident #6. The medications pulled for administration included 160 mcg/4.5 mcg Symbicort. A cup of water was placed on the resident ' s meal tray. The resident was observed as she inhaled two puffs of the aerosol medication. Nurse #2 did not prompt the resident to rinse her mouth out with water. Resident #6 then took her oral medications and drank (and swallowed) some water. Prescribing information was reviewed that included instructions for the patient to rinse the mouth with water without swallowing. On 02/10/2022, Nurse #2 was interviewed. She stated she thought Resident #6 did rinse her mouth with water but recalled she swallowed the water with her oral medications. Nurse #2 was aware that Resident #6 should have rinsed her mouth without swallowing after she used the inhaler. On 02/10/2022 at 3:10 PM, the Director of Nursing was made aware of the medication error. The Director of Nursing stated the nurses should follow the 6 rights of medication administration to prevent medication errors.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		3/11/22

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F 761	Continued From page 13 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep unattended medications stored in a locked medication cart for 1 of 4 medication carts observed (200 hall medication cart). The findings included: On 02/09/2022 at 3:10 PM, during an observation of medication administration, Nurse #1 was observed to take a resident ' s medications into the room leaving the medication cart unlocked in the hallway where a resident was sitting in his	F 761	* Nurse # 1 was immediately educated by the Director of Nursing on 2/9/2022 regarding the policy to always keep the medication cart locked/secured if unattended. No residents were adversely affected by cart being left unattended. * The Administrator and the Director of Nursing audited all of the other medication carts in the facility on 2/9/2022. No other medication carts were left unlocked.	

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F 761	Continued From page 14 wheelchair and staff were observed walking by. On 02/09/2022 at 3:11 PM, an interview was conducted with Nurse #1 who stated she knew that cart was supposed to be kept locked when unattended and she thought she did lock it. On 02/09/2022 at 3:30 PM, the Administrator, Director of Nursing and Corporate Nurse Consultant were notified of the medication cart being left unlocked while unattended.	F 761	* The Director of Nursing/designee will educate all licensed nurses and medication aides on procedure of locking/securing the medication carts when left unattended by 3/11/2022. * An audit tool was developed to monitor medication carts to ensure they are locked when unattended. Audits will be completed on random medication carts on random shifts three times a week for four weeks, then weekly for three months. Auditing will begin the week of 3/14/2022. The results of these audits will be reviewed in QAPI to ensure compliance.	