STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 The survey team entered the facility on 10/7/24 to conduct a recertification survey and complaint investigation. The survey team was onsite 10/7/24 through 10/14/24. Additional information was obtained offsite on 10/21/24 through 10/24/24. Therefore, the exit date was 10/24/24. The facility was in compliance with the requirement at CFR 483.73, Emergency Preparedness. Event ID# EGNU11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and complaint investigation was conducted from 10/7/24 through 10/14/24. Additional information was obtained offsite on 10/21/24 through 10/24/24. Therefore, the exit date was 10/24/24. The following intakes were investigated NC00223319, NC00217462, NC00222158, NC00221637, NC00221559, NC00219721, NC00212214 and NC00208571. Six of the 22 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tags F684 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 02/09/24 and was removed on 10/15/24. An extended survey was conducted.	F 000		
F 583	Personal Privacy/Confidentiality of Records	F 583		11/15/24

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

Electronically Signed | 11/12/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 583 SS=D	Continued From page 1 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure residents personal health	F 583	DISCLAIMER: Preparation and/or execution of this Plan of Correction does	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 583	Continued From page 2 information by leaving shift report documentation and a medication cart laptop unattended with resident information exposed in an area accessible and visible to the public on 1 of 3 Medication Carts (600 Hall Medication Cart). The findings included: While walking down the 600 hall, an observation was completed on 10/10/24 at 10:36 AM of the 600 Hall Medication Cart inclusive of the medication cart laptop which was unattended. The laptop displayed resident personal health information including names, medications, and diagnoses. The 600 Hall shift report documentation was also observed to be face up which displayed resident personal health information. Staff was observed passing by the 600 Hall Medication Cart. On 10/10/24 at 10:38 AM Nurse #4 returned to the 600 Hall Medication Cart. Nurse #4 closed the laptop screen and verbalized her medication cart was locked but she forgot to close her laptop. An interview was completed with Nurse #4 on 10/10/24 at 10:39 AM. Nurse #4 stated she was retrieving dry cereal for a resident and forgot to close her medication cart laptop. Nurse #4 explained she should have closed the medication cart laptop while not in attendance. Nurse #4 also voiced she should have turned her shift report documentation over while not in attendance of the 600 Hall Medication Cart. An interview with the interim Director of Nursing (DON) was completed on 10/10/24 11:16 AM. The interim DON revealed that Nurse #4 should have locked her laptop screen prior to leaving the	F 583	not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. F583 The residents whose health information was displayed on the medication cart experienced no harm. On 10/10/24, Nurse #4 closed her computer and turned her report sheet over. On 10/10/24, the Interim Director of Nursing educated Nurse #4 to ensure residents personal health information is protected. On 10/10/24, there were 14 residents residing in the 600 hall where Nurse #4 was assigned. There were no further observations of incidents with residents' personal health information. Beginning 10/29/24, the Director of Nursing re-educated all nurses on the importance of and need to protect personal health information. Any staff members who do not receive the training by 11/13/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 11/7/24, the Director of Nursing and/or designee will complete an audit 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 583	Continued From page 3 medication cart unattended. The interim DON further stated that the nurse should have turned over her clip board to protect resident health information. An interview with the Director of Nursing Services was completed on 10/14/24 at 4:07 PM. The Director of Nursing Services explained anytime staff were not with their medication cart the medication cart should be locked. The Director of Nursing Services continued to explain that staff should lock or lower their computer screen so that protected health information (PHI) was not exposed and shift report documentation should also be flipped over so that PHI was not exposed and no one could read as they passed by. An interview with the unlicensed Administrator was completed on 10/14/24 at 4:34 PM. She stated staff should lock or minimize their laptop screen or turn the medication cart towards the wall so the public cannot view protected health information. The unlicensed Administrator further stated that shift report documentation should be flipped over when the nurse left the medication cart unattended.	F 583	times weekly at random times to monitor compliance with protection of health information weekly for 12 weeks. Any identified issues will be corrected at that time. Results of the auditing will be shared with the Administrator weekly and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The Director of Nursing is responsible for this corrective action. Plan of Correction Date is 11/15/24	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 684	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with hospital system's transportation staff (Driver #1), Passenger Services Manager and Nurse Practitioner (NP), the facility failed to leave Resident #45 in place for a clinical assessment of injury after a fall that occurred during transport. Resident #45 was being transported to dialysis in a hospital system owned transport van. Driver #1 made a sudden stop which caused Resident #45 to slide forward out his wheelchair onto the van floor when his seatbelt loosened. Driver #1 pulled the van into the median of the road and attempted to transfer Resident #45 back into his wheelchair. When Driver #1 was unsuccessful in transferring Resident #45 back to his wheelchair, she continued to transport Resident #45 to the dialysis center while the resident was seated on the floor of the transportation van. Driver #1 was not qualified to provide a comprehensive physical assessment to determine if the resident sustained any injuries. Resident #45 did not sustain any injury, however there was a high likelihood of serious injury after sliding out of his wheelchair onto the floor of the vehicle when the driver had to suddenly apply brakes to avoid hitting pedestrians. This deficient practice occurred for 1 of 3 sampled residents reviewed for quality of care (Resident #45). The immediate jeopardy began on 2/9/24 when Resident #45 was not physically assessed for injury before being moved and was transported to dialysis while seated and unsecured on the floor of the transportation van. The immediate jeopardy was removed on 10/15/24 when the facility implemented a credible allegation of immediate	F 684	F684 On 2/10/24, Resident #45 was assessed by the Physician and no injuries were noted. Resident #45 continues to reside at the facility and is transported to off-campus appointments without incident. Driver #1 was removed from transporting facility residents to any off-campus appointments effective on 10/11/24. On 10/12/24 and 10/13/24, residents who had been transported by the transportation service within the previous 30 days were interviewed by members from the Interdisciplinary team, specifically the Resident Liaison, Rehab Manager, Activity Director and Licensed Practical Nurse/Unit Coordinator regarding any incidents or accidents where the resident was not immediately assessed for injuries occurred in transport. For residents who were not able to be interviewed, the assigned transportation companions were interviewed 10/12/24 and 10/13/24. There were no additional incidents reported of drivers moving residents after an incident without being first assessed by Emergency Medical Services or licensed nurse/physician. On 10/11/24 and 10/13/24, the Passenger Services Manager reviewed incident reports and communicated directly with all drivers that provided services to the facility and found no evidence of any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 5 jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm that is immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: The Motor Vehicle Accident and Emergency Reporting procedure updated 6/23/23 included a policy that stated health care passenger service drivers would report a motor vehicle accident or medical/vehicle emergencies immediately. The supervisor should be called (number listed) to resolve any urgent or emergency situations concerning the driver, the delivery or pick-up of passengers, and vehicle related problems at any time. The procedures included if patient starts to slide or shift while in wheelchair during transport - driver must pull over when safe to do so and seek help. i.e. Call 911 - fire department, pull vehicle onto the shoulder of the road; assess patient and/ passenger to determine if emergency medical assistance was needed and if patient or passenger was injured, report this to your supervisor immediate so an online incident report can be done via "CARE Event" (A Care Event is an incident/accident report that involves resident safety). Resident #45 was admitted to the facility on 1/19/24 with diagnoses that included generalized weakness, end stage renal disease and hypertension. Review of the admission Minimum Data Set (MDS) assessment dated 1/26/24 indicated Resident #45 was cognitively intact. The MDS further indicated he required	F 684	deficient practice during transport within the previous 30 days. The Passenger Services Manager also asked all drivers, including Driver # 1, if there were any accidents/incidents that occurred on transport that were not reported within the previous 30 days and the driver□s responses indicated that there had not been any accidents/incidents that had not been reported. On 10/14/24, the Passenger Services Manager revised the "Motor Vehicle Accident & Emergency Reporting Procedure" policy to reflect that for skilled nursing home residents, drivers are not to move patient until assessed by Emergency Medical Services or licensed nurse/physician. All van drivers received education by 10/14/24. Any van drivers who did not receive education by 10/14/24 (due to FMLA, leave, etc.) were required to complete education prior to working a scheduled shift. All van drivers hired after 10/14/24 will be required to complete this training and education upon hire. Education will be required during new hire orientation and annually. Beginning 10/12/24, the Passenger Services Manager began immediately notifying and providing all transportation services incident reports involving nursing home facility residents to the Administrator and Director of Nursing to ensure that timely resident assessments post medical/vehicle emergencies were completed. As of 11/8/24, no incidents had occurred.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 684	Continued From page 6 substantial/maximum assistance (helper does more than half of the effort) to go from a lying position to sitting, utilized a manual wheelchair and received dialysis. An interview was conducted with Resident #45 on 10/11/24 at 5:00 PM. Resident #45 stated he recalled an incident in which he slid from his wheelchair in the transportation van while going to his dialysis appointment. He further stated the brakes [when the driver applied brakes, it] threw him out of the chair. Resident #45 revealed he had gotten help from emergency medical service (EMS) staff to get back into his wheelchair. He stated Driver #1 slammed on brakes and he did not touch his seatbelt. Driver #1's witness statement dated 2/9/24 at 2:45 PM read "Driver #1 was driving down [Highway] 52 South towards the dialysis center. Some pedestrians started to run out in the front of her and Driver #1 had to put on brakes suddenly. Somehow the seatbelt came loose, and Resident #45 slid out of wheelchair onto the floor. Driver #1 pulled into the median to check on Resident #45 and attempted to get him up. Resident #45 stated he wanted to stay there and just take him on to his appointment. Once at dialysis, Driver #1 asked for help from dialysis staff. The Dialysis Staff said they could only help if Resident #45 was visible in the building. Driver #1 called 911 to help. Resident #45 stated he was not hurt to the medic on the phone, and they came and got him back in the chair. Driver #1 took Resident #45 in dialysis center for his appointment." Interview with Driver #1 on 10/10/24 at 4:09 PM revealed she could not recall the date of the incident but recalled a van incident that occurred	F 684	Incident reports submitted will be reviewed 5 times a week for 90 days and weekly thereafter for monitoring. All residents who experience transport by wheelchair van will be interviewed for the first week, 50% of residents who experience a wheelchair van transport will be interviewed weekly for 90 days. Any concerns will be immediately addressed an reported to the Administrator. Results of the monitoring will be shared with Quality Assurance and Performance Improvement (QAPI) ongoing. The Administrator is responsible for this corrective action. Plan of Correction Date 10/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 7	F 684		

with Resident #45. She stated she was transporting Resident #45 to dialysis when she observed 2 pedestrians that appeared to be darting in the roadway. She slammed on brakes. When she slammed on the brakes, Resident #45 slid from his wheelchair, his seatbelt came loose and he landed on the van floor. She indicated it was the force of the van stopping that made the resident's seatbelt come loose and Resident #45 landed on the van floor. She stated she stopped the van and tried to put Resident #45 back in his chair. She could not get him in the chair, and he stated he did not want help. Driver #1 stated she was close to the dialysis center, so she drove Resident #45 while he was seated on the floor of the transportation van. She indicated she should have contacted 911 to get Resident #45 back into his wheelchair and not drive with him on the floor of the van. Following the incident, she received education to call 911 if a fall happened on transport and she shouldn't move a resident. She further stated she had seen the video of the incident as there was a camera on the transportation vans.

An observation of video footage (visual and audio) of the van incident dated 2/9/24 was conducted with the Administrator on 10/11/24 at 2:31 PM. The video footage revealed a date of 2/9/24 and began at 11:43 AM. The camera was mounted in the front of the van and provided a view toward the rear of the van. Resident #45 originally seated behind the driver in the middle isle of the van. At 11:49 AM in transport, Resident #45 was observed to lean forward as his seatbelt was observed to come from his right side (where it was fastened) to his left. Resident #45 was observed to lean to his right side then slide forward out of his wheelchair in the aisle and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 8	F 684		

then fall to his right. After falling to his right, Resident #45 was no longer visible through the video (behind passenger seat). His wheelchair could still be seen in the upright position. Driver #1 was observed to stop the transportation van in the road's median and stated someone ran out in front of her. Driver #1 then exited the driver's seat and entered the side door of the transportation van. She was overheard to tell Resident #45 "You going to have to help me out now." Resident #45 was heard telling Driver #1 she was going to have to get some help. Driver #1 was observed to attempt to get the resident back up into his wheelchair as evidenced by picking him up under both arms. Resident #45 was observed sliding back out of his wheelchair back onto his bottom to the floor of the transportation van. Driver #1 then positioned Resident #45's back against his wheelchair while he was seated on the floor while telling him to hold on. Driver #1 was further observed to get back in the driver's seat. She stated she would drive slow. She also stated Resident #45 shouldn't have taken his seatbelt off. Driver #1 transported Resident #45 to the dialysis center. At 11:53 AM Driver #1 was observed pulling into the dialysis center parking covered parking deck. Resident #45 could be heard breathing heavy and moaning. Driver #1 was observed to go into the dialysis center, and then shortly after came back out to the transportation van. Within distance of the surveillance video, Driver #1 was observed to make a phone call at 11:55 AM (not within distance to overhear conversation). Driver #1 was observed to meet emergency medical services (EMS) upon arrival at 12:08 PM. Two EMS personnel were observed to assist Resident #45 back into his wheelchair at 12:10 PM. EMS were observed not to take vital signs or check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 684	Continued From page 9	F 684		

Resident #45 for injuries. After EMS transferred Resident #45 into his wheelchair they exited the transportation van. Driver #1 was observed taking Resident #45 into the dialysis center at 12:12 PM.

According to contact with the local EMS agency on 10/22/24, a report was not made. EMS attendants observed in the video footage did not document the event.

Interview with Passenger Services Manager on 10/11/24 at 2:00 PM revealed when an incident occurred during transport, the driver should contact dispatch office. After watching the video footage she indicated following the incident, Driver #1 should have contacted 911 to assist her transferring Resident #45 back into his wheelchair. Driver #1 should not have attempted to transfer Resident #45. She indicated that due to the investigation, Driver #1 was reeducated regarding the seatbelt strap, transporting a secured resident and contacting 911 for assistance. She further indicated it was not part of the procedure to drive with a resident on the floor of the van unsecured.

On 10/14/24 at 9:03 AM the Unit Manager stated she had not completed an incident report for the fall but did put the incident in a "care event". She continued that generally, when a resident had a fall, the facility would assess the resident before moving them. Assessing the resident prior to getting him up was to ensure there were no fractures or anything that could cause more damage if moved.

Interview with the Nurse Practitioner on 10/14/24 at 11:00 AM initially indicated she did not believe

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 10	F 684		

the resident had the dexterity to unhook his seatbelt. She stated there should be an assessment of the resident before he was assisted up from the floor of the transportation van. The assessment would have included his level of consciousness, a quick neurological check to see if moving all extremities, baseline mentation, looking for trauma, blood, bruising or any signs of injury. A body assessment should have been completed to identify any abrasions that could have occurred due to the incident. Resident #45 was not someone who could be lifted because Resident #45 cannot assist.

An interview with Director of Nursing Services, on 10/14/24 at 3:26 PM was conducted. She stated she had seen the video of the incident involving Resident #45 while he was being transported to his appointment. She further revealed Driver #1 would not have been able to assess the resident due to not being licensed. She indicated Driver #1 also continued to transport Resident #45 following the fall while he was seated on the floor of the transportation van. Driver #1 should have contacted 911 for assistance.

Interview with the Administrator on 10/14/24 at 2:12 PM stated she was not clinical and was not involved with Resident #45's assessment following the incident Driver #1 should have not attempted to pick up Resident #45 from the floor of the van and should not have continued to transport Resident #45 while seated on the floor of the transport van. Resident #45 should be assessed before he was moved, and she assumed EMS would have assessed him.

The facility was notified of immediate jeopardy on 10/11/24 at 7:17 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 11	F 684		

The facility provided the following immediate jeopardy removal plan.

Identify those recipients wo have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 2/09/24 Resident #45 was at the dialysis clinic when the Administrator was notified by a staff member that Resident #45 experienced a fall while in van transport. Driver #1 did not notify the facility administrator nor her supervisor, the Passenger Services Manager, about the accident.

On 2/09/24 the Administrator contacted the Passenger Services Manager to begin an investigation and require education of Driver #1.

On 2/09/24 Driver #1 put on the brakes suddenly and Resident #45 slid from his wheelchair onto the floor. Driver #1 stated that she did attempt to get Resident #45 up however Resident #45 stated to just to leave him on the van floor and take him to the Dialysis Clinic. Driver #1 then proceeded to call 911 for assistance. Driver #1 asked Resident #45 if he was ok and Resident stated that he was. Resident #45 stated to 911 personnel that he was not hurt, and they moved him back to the wheelchair. After Resident #45 was transferred to his chair by EMS (Emergency Medical Services) staff, Resident #45 stated that he had to go to the restroom Resident #45 required assistance prior to being dialyzed, Driver #1 transported Resident #45 back to the facility to receive care and Driver #1 then transported Resident #45 back to the Dialysis Clinic to be dialyzed without further incident. Driver #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 12	F 684		

returned Resident #45 to the facility after dialysis was completed.

There was no documentation that the nurse assigned to Resident #45 completed an assessment after incident on 2/9/24.

Resident #45 was assessed by physician on 2/10/24 not related to this incident and no injuries were noted.

The Passenger Services Manager provided documentation to validate that Driver #1 received education on the following policies and procedures on 2/13/24 and on 3/2/24: "Expectations of Passenger Services Drivers', "Mobile Cellular Device", "Proper Transport Loading and Unloading Wheelchair Patients", "General Safety"," Motor Vehicle Accidents& Emergency Reporting Procedures" to the facility administrator.

On 10/14/24, the Passenger Services Manager notified the facility administrator that on 2/12/24 and 2/13/24, the Lead Driver accompanied Driver #1 on transportation routes and provided one-to one re-training as assigned by the Passenger Services Manager. Driver #1 reported back to work on 2/12/24.

The Passenger Services Manager provided documentation to validate that Driver #1 received related education on the following policies and procedures: "General Safety"," Motor Vehicle Accidents & Emergency Reporting Procedures", "Expectations of Passenger Services Drivers", "Proper Transport Loading and Unloading Wheelchair Patients" and "Mobile Cellular Device" to the facility administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 13	F 684		

Documentation of training and acknowledgment was signed on 2/13/24.

On 3/2/24 Driver #1 was re-educated again on the following Policies and procedures: "General Safety," Motor Vehicle Accidents & Emergency Reporting Procedures", "Expectations of Passenger Services Drivers", "Proper Transport Loading and Unloading Wheelchair Patients" and "Mobile Cellular Device" and documentation of training was provided to the facility administrator. Documentation of training and acknowledgment was signed on 3/2/24.

All residents who use wheelchair transportation services for medical appointment[s] are at risk of experiencing an adverse outcome as a result of this deficient practice. Current residents who had been transported by the transportation service within the last 30 days were interviewed on 10/12/24 and 10/13/24 by members from the IDT team, specifically the Resident Liaison, Rehab Manager, Activity Director and LPN/Unit Coordinator regarding any incidents or accidents where the resident was not immediately assessed for injuries occurred in transport. For current residents who were not able to be interviewed, the assigned transportation companions were interviewed 10/12/24 and 10/13/24 and no evidence of any additional deficient practice during transport was reported where drivers moved residents after an incident without being first assessed by 911 personnel or licensed nurse/physician.

The Passenger Services Manager was interviewed by the facility Administrator on 10/11/24 and 10/13/24 related to any events of deficient practice reported from all drivers within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 14	F 684		

the last 30 days which required immediate assessment for injuries. The Passenger Services Manager reviewed incident reports and communicated directly with all drivers providing services to the facility and found no evidence of any deficient practice during transport review period reported. The Passenger Services Manager also asked all drivers, including Driver # 1, if there were any accidents/incidents that occurred on transport that were not reported in the last 30 days and the drivers' responses indicated that there had not been any accidents/incidents that had not been reported during review period.

On 10/13/24, the Passenger Services Manager confirmed with the facility administrator that interviews; and a review of transportation records for that past 30 days found no evidence of deficient practice with drivers providing service to residents at the facility.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The facility will take immediate action by informing Hospital system transportation services to remove Driver #1 from transporting facility residents to any off-campus appointments, Effective at 8:40 pm on 10/11/24.

On 10/12/24, the Passenger Services Manager and the Facility Administrator reviewed the policy, "Motor Vehicle Accident & Emergency Reporting Procedure" and found the policy did not address skilled nursing facility residents and the policy section regarding emergencies was revised on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 15	F 684		

10/14/24 to reflect that for skilled nursing home residents, drivers are not to move patient until assessed by EMS or licensed nurse/physician, as listed below:

Medical/Vehicle Emergencies:
If patient starts to slide or shift while in wheelchair during transport - Driver must pull over when safe to do so and seek help. i.e. Call 911 - fire dept.
Each driver has a cell phone provided and other communication devices which are owned and managed through Mobile Medical Services not the facility.
Pull vehicle onto the shoulder of the road
Evacuate Patients and or passengers from the vehicle quickly and safely if vehicle is on fire
Administer first aid and use fire extinguishers as appropriate
Do not move patient. Patient must be accessed by Emergency Medical Services (EMS) or licensed nurse/physician
Drivers will immediately notify the Passenger Services Manager in the event of an incident/accident during transport
Call Atrium Health Security or contact 9-1-1 as needed for emergency help and update Mobile Medicine Passenger Services Dispatch at (704)512-7920
If patient or passenger is injured, report this to your supervisor immediately so an online incident report can be done via "CARE Event" (A Care Event is an incident/accident report that involves resident safety)
Driver must remain with patients and/or passengers until all are transported to an emergency care facility if necessary
Have Atrium Health Security notify supervisor and department head as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 684	Continued From page 16	F 684		

On 10/14/24 the facility administrator notified the Passenger Services Manager to immediately notify the facility administrator or charge nurse in the event of an incident/accident during transport.

All current van drivers will receive education by 10/14/24. Any current van drivers who do not receive education by 10/14/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. All van drivers hired after 10/14/24 will be required to complete this training and education upon hire. The education will be required during annual orientation.

Beginning 10/12/24, the Passenger Services Manager will immediately notify and provide all transportation services incident reports involving nursing home facility residents to the Administrator and Director of Nursing to ensure that timely resident assessments post medical/vehicle emergencies are completed.

The alleged date of immediate jeopardy removal was October 15, 2024.

On 10/16/2024 the facility's immediate jeopardy removal was validated by the following:

The facility provided documentation to support immediate jeopardy removal including education provided by the Passenger Services Manager to the current drivers. Drivers were interviewed and they reported the procedure to follow if a resident falls on the van, including pulling the van over as soon as possible, calling 911 to request an assessment of the resident by an EMT, contacting the dispatcher to report the accident or incident. Drivers verbalized they were not to move

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 684	Continued From page 17 the resident until an EMT, nurse, or physician had assessed the resident for injuries. The immediate jeopardy was removed on 10/15/2024.	F 684		
F 685 SS=E	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, family, resident and Nurse Practitioner (NP) interviews, the facility failed to obtain a referral, schedule or arrange an audiology appointment, or and screening for a resident with sensory neural hearing loss whose hearing aids did not fit properly for 1 of 1 resident (Resident #45) reviewed with hearing loss. The findings included: Resident #45 was admitted to the facility on 1/19/24 with a diagnosis that included cognitive decline and asymmetrical sensory-neural hearing loss.	F 685	F 685 On 10/15/24, Resident #45 was provided with an amplifier which will be charged at the nursing station at night. On 11/7/24, the resident□s personal Audiologist was contacted to schedule an appointment to address the resident□s hearing needs. The earliest appointment available with the resident□s personal Audiologist was on 12/6/24. On 11/8/24, the Director of Nursing contacted the physician to obtain orders to provide the resident with the amplifier and to charge at the nursing station at night. On 11/8/24, the	11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 685	Continued From page 18 The care plan dated 1/22/24 indicated Resident #45 had a hearing deficit due to hearing loss as evidence by wearing bilateral hearing aids. The goal stated Resident #45 would understand verbal communication as evidence by appropriate response. The interventions included involve in activities that don't depend on hearing, parties, craft games, and small groups. Speak clearly/distinctly, adjust tone and volume of voice as necessary and monitor for changes in condition. A nursing note dated 2/8/24 indicated Resident #45 arrived at the facility via stretcher accompanied by Emergency Medical Services following a hospitalization. Resident #45 was alert, oriented and able to verbalize his needs. The note continued that Resident #45 was hard of hearing (HOH) and had hearing aids. A Speech Therapy note dated 3/6/24 included Resident #45 required written down information (visual cues), as Resident #45 was extremely HOH and hearing aids did not work. Review of Occupational Therapy note dated 3/8/24 stated Resident #45 asked, "can you put my hearing aids in". The note did not indicate if Resident #45's hearing aid were put in. Review of a Social Worker (SW) note written by the previous SW dated 8/7/24 stated Resident #45 was watching television with the volume loud as he was HOH. The note continued that Resident #45 had a new roommate who was trying to visit with his wife but was unable to due to Resident #45's loud television. Resident #45 gave the Social Worker permission to turn	F 685	Interdisciplinary Team met to review the resident□s communication needs and updated the resident□s care plan, accordingly. The resident□s care plan interventions were updated and communicated to the staff. On 11/8/24, the Activity Director interviewed Resident #45, and he stated that he has had the amplifier a couple of weeks, and the amplifier was working just fine. Resident included that he was satisfied with the Audiologist appointment date of 12/6/24. Immediately following the 12/6/24 Audiology appointment to address issues associated with Resident #45□s hearing aids, NA #3 will be re-educated by the Director of Nursing on the correct application of Resident #45□s hearing aid. On 11/8/24, NA #1 will be re-educated on each nurse and nurse aide having the responsibility to apply resident□s hearing aids. On 11/8/24, Nurse #2 will be re-educated by the Director of Nursing on each nurse and nurse aide having the responsibility to apply resident□s hearing aids. On 11/8/24, NA#4 will be educated by the Director of Nursing on accessing the electronic medical record information to identify residents care needs. On 11/8/24, NA #5 will be re-educated by the Director of Nursing on accessing the electronic medical record information to identify residents care needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 685	Continued From page 19 volume down but seemed aggravated. Resident #45 was alert and appeared oriented. It was a difficult to converse with Resident #45 due to him being extremely HOH. Resident #45 asked the Social Worker to write a question on paper and he answered them appropriately. An interview was attempted with the previous SW. He was unable to be reached by phone. Review of quarterly Minimum Data Set (MDS) assessment dated 9/13/24 indicated Resident #45 was cognitively intact. Resident #45 was further coded as having moderate hearing loss and was using hearing aids. An observation of Resident #45 on 10/7/24 at 4:50 PM revealed him to be watching television with headphones. The headphones were held to his ears with tape attached across both earlobes. The tape was holding in place the wires attached to the earbuds. An interview and observation was conducted (via writing) with Resident #45 on 10/10/24 at 1:40 PM. Resident #45 was observed to be watching television in his room with earphones taped in his ears. Resident #45 revealed he had hearing aids, but no one knew how to put them in. Resident #45 stated he could not put them in himself because his hands didn't work like they used to. Resident #45 stated his hearing aids were in a basket on his nightstand. Observation of Resident #45's nightstand revealed a basket with random items. At the bottom of the basket was a chargeable hearing aid case. There were 2 hearing aids observed in the unplugged chargeable hearing aid case.	F 685	On 11/8/24, Nurse #5 will be re-educated by the Director of Nursing on accessing the electronic medical record information to identify residents care needs. On 11/12/24, the Unit Manager or designee, will assess every resident with hearing devices to assure the devices were working correctly and fit correctly. Beginning 10/29/24, the Director of Nursing re-educated all nurses on the need for proper fit and function of hearing aids and for obtaining appropriate services to maintain function. Beginning 11/5/24, the Director of Nursing re-educated all nurse aides on the need for proper fit and function of hearing aids and for obtaining appropriate services to maintain function. Beginning 11/11/24, the Director of Nursing will re-educated all nursing staff on accessing the electronic medical record information to identify residents care needs and that nurses and nurse aides have the responsibility to apply residents hearing aids. Any staff members who do not receive the training by 11/13/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 11/7/24, the Director of Nursing and/or the Charge Nurse will audit 2 residents with hearing aids weekly for 12 weeks. Any identified issues will be corrected at that time. Results of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 685	Continued From page 20 During an interview with the SW on 10/10/24 at 2:04 PM revealed Resident #45 was hard of hearing and required staff to increase their tone or write to him. Resident #45 used headphones (earbuds) to watch TV because he needed the TV loud to hear it. The SW was not aware of any issues regarding Resident #45's hearing aids not working properly. She indicated if a resident had a referral for an outside appointment, it would be scheduled by transportation department. An interview with Resident #45's family member on 10/11/24 at 9:04 AM indicated he had spoken with the facility (name of staff and date unknown) regarding his family member's hearing aids. He stated when he visited the hearing aids were not in Resident #45's ears. He stated he had communicated to the facility (name of staff and date unknown) that they would have to be taken into the store they were purchased, because the store could service the device by turning the volume up or down and changing the filters. He indicated he did not believe the facility had taken the hearing aids to be serviced. He recalled having to take the device to the store to have the filters changed but he could not recall the date. An interview and observation with Nursing Assistant (NA) #3 on 10/10/24 at 1:44 PM revealed Resident #45 was very hard of hearing. She stated he had to get headphones for his television because he had it too loud. Resident #45 did have hearing aids, and they worked. Resident #45 was unable to put his hearing aids in without assistance. She indicated she has tried to put them in Resident #45's ears but they were weirdly shaped and sometimes she couldn't. She stated she has communicated to nurse (name unknown) that Resident #45's hearing aids	F 685	auditing will be shared with the Administrator weekly and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The Director of Nursing is responsible for this corrective action. Plan of Correction Date is 11/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 685	Continued From page 21	F 685		

were difficult to put in. She indicated she recalled the nurse coming in the room and trying and being unsuccessful. She stated his hearing aids did not use batteries but were kept in a charging device. NA #3 stated the last time she worked with Resident #45 she recalled putting in his hearing aids after Resident #45 requested them for a dialysis appointment. She further indicated she might be putting them in his ears wrong. During the observation of Resident #45's hearing aids, NA #3 stated the part that sat in the cartilage of Resident #45's ear did not fit correctly so they won't stay in his ears.

An interview with NA #1 on 10/10/24 at 2:37 PM revealed Resident #45 was very hard of hearing and wore hearing aids. She stated when working with him she had not tried to help him put his hearing aids in. Resident #45 has issues with his hands and was not able to put his hearing aids in himself. She further indicated he had not been wearing them and she wasn't sure if it was the responsibility of the nurse or the NA to put them in. She had to get really close to Resident #45 for him to hear, and stated he always said he can't hear anything. NA #1 indicated NAs would look at the resident summary to identify what was required for each resident but could not recall if Resident #45's summary indicated apply hearing aids.

Nurse #2 was interviewed on 10/10/24 at 2:03 PM and revealed she was assigned to Resident #45. She stated Resident #45 did have hearing aids but due to not working with Resident #45 for a week she was unsure of when the last time he wore them. Resident #45 was unable to put his hearing aids in himself. Nurse #2 indicated she had never put them in due to it being an NA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 685	Continued From page 22	F 685		

responsibility.

An interview with NA #4 on 10/10/24 at 3:16 PM indicated Resident #45 did not wear hearing aids. She stated he wore earbuds to watch television. There was tape on the earbuds to keep them from falling out of Resident #45's ears. She indicated it was her second day and this was her first time working with Resident #45. She indicated she was unsure if there was a guide that identified what the resident's activities of daily living needs were as she was new and still taking direction from NA#5. Resident #45 was very hard of hearing. She indicated she had to almost holler at him for Resident #45 to hear her.

An interview with NA #5 on 10/10/24 at 3:32 PM revealed she recalled being assigned to Resident #45. She stated she had not seen Resident #45 with hearing aids and had not observed hearing aids in his room. Resident #45 had told her he was hard of hearing and that he preferred for staff to get close to his ear when speaking to him. NA #5 stated the electronic medical record would identify if a resident wore hearing aids or had to have hearing aids applied. She had not observed in the medical record that Resident #45 had hearing aids or needed assistance applying them.

An interview with Nurse #5 on 10/10/24 at 3:20 PM indicated he had worked with Resident #45. He further revealed he had not seen Resident #45 with hearing aids. Nurse #5 stated Resident #45 did wear headphones when he watched TV because he needed it to be loud. The tape on his ears were to hold the headphones in place. When speaking to Resident #45 he had to speak very loudly so Resident #45 could hear him. He stated if hearing aids were not documented in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 685	Continued From page 23	F 685		

resident record on the Treatment Administration Record (TAR) or care plan, he wouldn't have looked for them.

An interview with the Interim Director of Nursing on 10/10/24 at 2:16 PM indicated Resident #45's hearing aids were placed in his ears when staff could get them in his ears. She recalled having a hard time putting Resident #45's hearing aids in one day when he had an appointment to dialysis. The Interim Director of Nursing couldn't get them in and had to request assistance from another nurse. She indicated it was the NAs that would be tasked with putting in his hearing aids. She did not get a referral for Resident #45's hearing aids or notify the physician because a nurse (name unknown) was able to get them in. Issues with hearing aids should be brought to the attention of administration so the SW could do something like get an appointment. She was unsure if the concerns with Resident #45 made it to the SW.

The unlicensed Administrator was interviewed on 10/10/24 at 2:06 PM. She stated Resident #45 wore earphones when he watched television. She stated she had not personally assisted Resident #45 with applying his hearing aids. From staff communication, Resident #45 did not always wear his hearing aids, but she was unsure of the cause. The unlicensed Administrator just understood he didn't like to wear them. She revealed if Resident #45's hearing aids were not fitting appropriately the facility should have gotten him an appointment and discussed the hearing aids with the Resident's family, especially if it was hindering Resident #45's care. The unlicensed Administrator recalled the SW discussing the hearing aids with the resident's family but was unaware if there was a note about the discussion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 685	Continued From page 24 An interview with the NP on 10/14/24 at 11:00 AM revealed she recalled Resident #45 being hard of hearing. She indicated she did not recall any issues regarding his hearing aids. Resident #45 did not have the dexterity (skill in performing task, especially with the hands) to put in his own hearing aids. The NP stated if the hearing aids were not working or not fitting properly Resident #45 should have been sent out for a referral or at least be evaluated.	F 685		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of audio/video footage, and Nurse Practitioner (NP), Passenger Services Manager, resident and staff interviews, the facility failed to provide safe transportation for Resident #45 in the hospital system transportation van to the dialysis center. On 2/9/24 while en route Driver #1 stopped abruptly, and Resident #45 slid out of his wheelchair to the floor of the van. Driver #1 was unable to assist Resident #45 back into his wheelchair and proceeded to drive to the dialysis center with Resident #45 sitting on the floor of the van. In addition, on 8/12/24, Driver #1 failed to ensure the lift gate was in the elevated position	F 689	F689 On 2/10/24, Resident #45 was assessed by the Physician and no injuries were noted. Resident #45 continues to reside at the facility and is transported to off-campus appointments without incident. On 8/12/24, Resident #62 was assessed by the Unit Manager and Nurse Practitioner. No injuries were noted. Driver #1 was removed from transporting	11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 25	F 689		

before unloading Resident #62 from the back from the van. Driver #1 stood behind Resident #62's wheelchair and wheeled Resident #62 towards the back of the van and lift gate. Driver #1 fell out of the back of the transportation van and Resident #62 and his wheelchair rolled out of the back of the transportation van and landed on top of Driver #1. There was a high likelihood of a serious adverse outcome or injury when the manufacturer's instructions for securing and unloading residents from the transportation van are not followed. This was for 2 of 5 residents reviewed for accidents (Resident #45 and Resident #62).

Immediate jeopardy began on 2/9/24 when Resident #45 fell to the floor of the transportation van while being transported to his dialysis appointment. Immediate jeopardy began on 8/12/24 for Resident #62 when Driver #1 wheeled the resident out of the back of the van with the lift gate in the grounded position. Immediate Jeopardy was removed on 10/15/24 when the facility implemented an allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" (no actual harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place are effective.

The findings included:

Review of manufacturer's instructions for the hospital system transportation van wheelchair securement system titled "B" Secure the Passenger included (undated):
1. Attach lab belts - use integrated stiffeners to feed belts through openings between seat backs and bottoms, and/or armrest to ensure proper fit

facility residents to any off-campus appointments effective on 10/11/24.

On 10/12/24 and 10/13/24, residents who had been transported by the transportation service within the previous 30 days were interviewed by members from the Interdisciplinary team, specifically the Resident Liaison, Rehab Manager, Activity Director and Licensed Practical Nurse/Unit Coordinator regarding any incidents or accidents. For residents who were not able to be interviewed, the assigned transportation companions were interviewed 10/12/24 and 10/13/24. There were no additional incidents or accidents reported during transport.

On 10/11/24 and 10/13/24, the Passenger Services Manager reviewed incident reports and communicated directly with all drivers that provided services to the facility and found no evidence of any deficient practice during transport within the previous 30 days. The Passenger Services Manager also asked all drivers, including Driver # 1, if there were any accidents/incidents that occurred on transport that were not reported within the previous 30 days and the driver□s responses indicated that there had not been any accidents/incidents that had not been reported.

Beginning 10/12/24, the Passenger Services Manager conducted in person training with
all transportation drivers assigned to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 26 around occupant. a. on the aisle side, attach belt with female buckle to rear tie down pin connector to ensure buckle rest on passenger hips. b. on the window-side attach belt with male tongue to rear tie-down pin connector and insert into female buckle 2. Attach shoulder belt - extend shoulder belt over passengers' shoulders and across upper torso and fasten pen connector onto lap belt Note: combination lap/shoulder belts serve as both window and window-side lab belt and shoulder belt. 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort. 1. Resident 45 was admitted to the facility on 1/19/24 with diagnoses that included generalized weakness, end stage renal disease and hypertension. Resident #45 was not on prescribed an anticoagulant (blood thinner). Review of the admission Minimum Data Set (MDS) assessment dated 1/26/24 indicated Resident #45 was cognitively intact. The MDS further indicated he required substantial/maximum assistance (helper does more than half of the effort) to go from a lying position to sitting. Resident #45 utilized a manual wheelchair for mobility and had no falls since admission. Review of Resident #45's nursing notes for the month of February 2024 did not reveal any documentation regarding him sliding from his wheelchair while on the transportation van. Review of a dialysis center Social Worker note dated 2/9/24 at 1:08PM stated "gave emergency contact to call to inform him that Resident #45	F 689	facility, including return demonstration of offloading and securement of passengers. The training included the Safety Briefing slide (providing a visual of the correct position for the liftgate); the Passenger Services Liftgate Use; Patient Safety Check requirements. Training and Education will also include offloading residents from the van and proper securement with the wheelchair van wheelchair and resident securement system according to the manufacturer's instructions. Competency skills checklist was completed for all drivers and continues annually upon orientation. Any transportation drivers who did not receive the education by 10/12/24 (due to FMLA, leave, etc.) were required to complete education prior to working a scheduled shift. All newly hired drivers assigned to the facility will be required to complete this training and education upon hire and all drivers will be required to complete this education Annually. Beginning 10/12/24, the Passenger Services Manager provided documented evidence of training and education of all assigned drivers to the Administrator and Director of Nursing. As of 11/8/24, training and education of all assigned drivers have been provided. Incident reports submitted will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 27 had a fall (while) being transported to treatment today." The "SNF Post Fall Debrief and Checklist" dated 2/9/24 had no time entered for the incident and the location was identified as the transportation van. Nurse #1 was identified as the assigned nurse. The brief description of the event stated, Resident #45 was noted to be on transport to an appointment when Resident #45 slid out of the wheelchair going down the road. Medics assisted Resident #45 back into his wheelchair. The "medication factors, factors that may have contributed to Event, Care planning and Behavioral factors were left blank. The document indicated that the Nurse Practitioner (NP) was notified on 2/9/24 with no time of contact, and Resident #45's family was notified on 2/9/24. The form was completed by the Unit Manager on 2/9/24. Review of the witness statement written by Driver #1 dated 2/9/24 at 2:45PM revealed "Driver #1 was driving down [name of highway] towards the dialysis appointment. Some pedestrians started to run out in front of her and Driver #1 had to put on brakes suddenly. Somehow the seat belt came loose, and Resident #45 slid out of wheelchair onto the floor. Driver #1 pulled into the median to check on Resident #45 and attempted to get him up. Resident #45 stated he wanted to stay there and just take him on to the appointment. At dialysis, Driver #1 asked for help, and they said they could only help if Resident #45 was visible in the building. Driver #1 called 911 to help. Resident #45 stated he was not hurt to the medic on the phone, and they came and got him back in the wheelchair. Driver #1 took Resident #45 in for his appointment.	F 689	reviewed 5 times a week for 90 days and weekly thereafter for monitoring. All residents who experience transport by wheelchair van will be interviewed for the first week, 50% of residents who experience a wheelchair van transport will be interviewed weekly for 90 days. Any concerns will be immediately addressed an reported to the Administrator. Results of the monitoring of training and education will be shared with Quality Assurance and Performance Improvement (QAPI) ongoing. The Administrator is responsible for this corrective action. Plan of Correction Date 10/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 28	F 689		

Resident #45 asked them to take him to the restroom. They said they could not so, they brought him back out so Driver #1 could take him back to the facility to change and use the bathroom. Once that was done, Driver #1 returned him to this appointment."

Review of dialysis nursing note dated 2/9/24 at 4:37PM stated Resident #45 slid out of his wheelchair in the transportation van with no apparent injury. EMS was called to assist in lifting the resident. The resident denied any problems or discomfort.

Interview with Driver #1 on 10/10/24 at 4:09PM revealed she could not recall the date of the incident but recalled a van incident that occurred with Resident #45. Driver #1 stated she was transporting Resident #45 to dialysis when she observed 2 pedestrians that appeared to be darting in the roadway, and she slammed on the brakes. When she slammed on the brakes, she observed through her rearview mirror, Resident #45 slid from his wheelchair, his seatbelt (combination lap/shoulder belt) came loose, and he landed on the van floor. Driver #1 stated she pulled over into the median, stopped the van and went to assist Resident #45. She stated when arrived at Resident #45 he was positioned on the floor face up with his head toward his chair and his legs towards the driver's seat. Resident #45's head was close to the van door and his wheelchair remined upright. Driver #1 indicated she tried to put Resident #45 back in his wheelchair and she could not. Resident #45 stated he did not want help with getting back in his wheelchair. Driver #1 stated she was close to the dialysis center, so she drove Resident #45 there while he was seated on the floor of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 29	F 689		

transportation van. Driver #1 also could not recall if she communicated the incident to anyone in the facility.

An interview was conducted with Resident #45 on 10/11/24 at 5:00 PM. Resident #45 stated he recalled an incident in which he slid from his wheelchair in the transportation van while going to his dialysis appointment. He further stated the brakes [when the driver applied brakes] threw him out of the wheelchair. Resident #45 revealed he had gotten help from emergency medical service (EMS) staff to get back into his wheelchair. He stated Driver #1 slammed on brakes and the resident did not touch his seatbelt.

Interview with Unit Manager on 10/11/24 at 11:11AM indicated she recalled being at the nursing station 2/9/24 when she overheard Driver #1 talking with staff members (could not recall names) about Resident #45 sliding out of his wheelchair during transport. The Unit Manager stated she questioned Driver #1 about the incident and Driver #1 stated Resident #45 had slid out of his wheelchair on his way to his dialysis appointment that day. Driver #1 explained that during the transport, someone ran across the road, and she had to slam on the brakes to avoid them. When Driver #1 slammed on the brakes, Resident #45 was holding onto his lunch bag, and when he got pushed forward, his lunch bag and hand unhooked his seatbelt. She indicated Driver #1 stated when Resident #45 slid to the floor, Driver #1 pulled over into the median, and she asked was Resident #45 ok. Driver #1 indicated she couldn't get him up and Resident #45 told her he wanted to go to dialysis. Driver #1 contacted Emergency Medical Services (EMS) when she arrived at the dialysis center, and they assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 30	F 689		

Resident #45 back into his wheelchair. The Unit Manager recalled Driver #1 bringing Resident #45 back to the facility that day from the dialysis center for incontinence care and then transporting him back to the dialysis center. The Unit Manager stated she believed she asked Driver #1 about the situation after she came back from the dialysis appointment and not when she brought Resident #45 back for incontinence care. She stated she filled out the "SNF post fall debrief and checklist" form dated 2/9/24, contacted the NP and Resident #45's family member. She recalled telling the current interim Director of Nursing (DON), Regional Facility Consultant #1 and the Administrator about Resident #45 having a fall while on the van. She stated she put a note in the flow sheet and documented that she contacted the provider but had not completed a detailed note about the incident.

In another interview with the Unit Manager on 10/11/24 at 11:53 AM, the unit manager indicated she followed up on the incident on 2/12/24. She stated she did not include interventions on the SNF post fall debrief and checklist form because she didn't deal with transportation. She further indicated Driver #1 was not employed by the facility and she was not sure what interventions the transportation department put into place.

The unlicensed Administrator provided a copy of an email dated 10/11/24 at 11:09AM requesting a copy of the "care event" related to the van incident on 2/9/24 from Passenger Services Manager. The response email dated 10/11/24 included the "Corporate Risk Management Care Event" dated 2/9/24 which stated Resident #45 slid out of his wheelchair during transport. Driver #1 advised that she had to brake suddenly, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 31	F 689		

Resident #45 slid out of his chair. The reporting employee was identified as the Passenger Services Manager. The "Corporate Risk Management Care Event" indicated there was no harm to Resident #45.

Interview with the Passenger Services Manager on 10/11/24 at 2:00PM revealed when an incident occurred during transport, the transporter/Driver should contact dispatch and in a lot of cases contact the family. The driver would also need to make contact with the Passenger Services Manager and provide information as it related to the incident immediately. A witness statement would also be requested. The Passenger Services Manager stated she included information regarding incidents on the transportation van in a "care event" (information regarding incidents on the transportation van). She further revealed she would conduct an internal investigation to identify what occurred and what could be done differently to prevent a recurrence. The Passenger Services Manager stated typically when she entered a care event she would alert the facility of the incident as well. She recalled Driver #1 notified her that Resident #45 had a fall during transport on 2/9/24. The Passenger Services Manager created a care event and obtained a statement from Driver #1. She could not recall if she notified the facility. She stated she was unsure if Resident #45 had any injuries due to the accident. The Passenger Services Manager explained during her investigation she reviewed the audio/video footage of the incident. The Passenger Services Manager stated she recalled hearing a click when Driver #1 fastened the combination lap/shoulder belt on the audio/video footage which led her to believe Driver #1 secured Resident #45 properly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 32	F 689		

However, she also stated the shoulder belt strap could have been more secure around Resident #45 due to her observing slack when she observed the video footage. The Passenger Services Manager indicated Driver #1 should have tightened the shoulder belt after connecting the device. In the video, Resident #45's lap belt inclusive of shoulder belt were observed to come off of Resident #45 (unfastened) and he slid out of his wheelchair onto the van floor. She indicated that due to the investigation Driver #1 was reeducated regarding the combination lap/shoulder belt, not transporting residents while unsecured and contacting 911 for assistance. The Passenger Services Manager further indicated it was not part of the procedure to drive with a resident on the floor of the transportation van. The Passenger Services Manager indicated in her internal investigation she did not make observations of the wheelchair to identify any potential malfunction or damage due to the incident. She stated it would be the facilities responsibility to assess the Resident's wheelchair after the event.

An observation of audio/video footage of the van incident dated 2/9/24 was conducted with the Administrator present on 10/11/24 at 2:31 PM. The video footage revealed a date of 2/9/24 and began at 11:43 AM. The camera was mounted in the front of the van and provided a view toward the rear of the van. Driver #1 was observed to get Resident #45 off the lift and roll him onto the back of the transportation van. She was further observed to attach the base of the wheelchair to tie downs and then place the combination lap/shoulder belt around Resident #45. Driver #1 pulled the shoulder strap and integrated lab belt from the left side of the van and connected the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 33	F 689		

belt to the right side of Resident #45 (no sound heard). The shoulder strap was observed to be loose as the shoulder belt was not snug around Resident #45's torso. (Slack was observed where the shoulder strap would retract). Driver #1 was not observed to check or adjust the lap or shoulder belt. Resident #45 was seated behind Driver #1 in the middle aisle of the van. At 11:49 AM Resident #45 was observed to lean forward as his lap belt inclusive of shoulder belt, were observed to unfasten, going from his right side (where it was fastened) to his left. Resident #45 was observed to lean to his right side then slide forward (feet first) out of his wheelchair into the van's aisle and then fall to his right side. Resident #45's wheelchair was observed to remain upright with tie downs still attached. After falling to the floor, Resident #45 was no longer visible on the video and Driver #1 was observed to stop the transportation van in the highway's median and stated someone ran out in front of her. Driver #1 then exited the driver's seat and entered through the side door of the transportation van. She was overheard telling Resident #45, "You going to have to help me out now." Resident #45 was heard telling Driver #1 she was going to have to get some help. Driver #1 was observed to attempt to get the resident back up into his wheelchair by picking him up under both arms. Resident #45's was observed sliding onto his bottom on the floor of the transportation van. Driver #1 then positioned Resident #45's in a sitting position with his back against his wheelchair while he was seated on the floor and telling him to hold on. Driver #1 was observed to get back in the driver's seat and stated she would drive slowly. She also stated Resident #45 shouldn't have taken his seat belt off and Resident #45 did not respond. Driver #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 34	F 689		

transported Resident #45 to the dialysis center. At 11:53 AM Driver #1 was observed pulling into the dialysis center's covered parking deck. Resident #45 could be heard breathing heavy and moaning. Driver #1 was observed to go into the dialysis center, and then shortly after came back out to the transportation van. Driver #1 was observed to make a phone call at 11:55 AM (not within distance to overhear conversation). Driver #1 was observed to meet emergency medical services (EMS) personnel upon arrival at 12:08 PM. Two EMS personnel were observed to assist Resident #45 back into his wheelchair at 12:10 PM And Driver #1 was observed taking Resident #45 into the dialysis center at 12:12 PM.

In a continued interview with the Unit Manager on 10/14/24 at 9:03AM. She stated she didn't overhear Driver #1 speaking of the incident until she returned with Resident #45 at the completion of his dialysis treatment. The Unit Manager stated she contacted Facility Consultant #1 as soon as she was made aware. She stated Regional Facility Consultant # 1, requested that she ask further questions about what occurred and had her reach out to Driver #1's supervisor to let them know about the van incident and obtain a statement. The Unit Manager revealed she communicated to the Passenger Services Manager on 2/9/24 that she wanted them to do an incident report/care event, and the Passenger Services Manager indicated they would handle the situation. The Unit Manager indicated she did not complete an incident report.

During an interview on 10/14/24 at 11:00AM the Nurse Practitioner (NP) initially indicated she was not made aware of Resident #45's fall while being transported to his dialysis appointment. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 35	F 689		

stated she was made aware (Friday or Wednesday) of last week. After a review of the SNF Post Fall Debrief Checklist report completed by the Unit Manager dated 2/9/24 the NP stated she may have been contacted but it wasn't to the extent of the resident sliding from his wheelchair, not being assessed and transported to his dialysis appointment while seated on the floor of the transportation van. The NP stated the Unit Manager might have notified her, but the NP indicated she would have thought she would have remembered being contacted if she was provided with the details of the incident. Looking at how the SNF Post Fall Debrief Checklist was written, it sounded as if the resident was just assisted back to his wheelchair. The NP further indicated she did not believe Resident #45 had the dexterity to unhook his seatbelt.

Interview with Regional Facility Consultant #1 on 10/14/24 at 2:00PM revealed she was notified by the Unit Manager by phone 2/9/24 that Resident #45 had a fall on the transportation van while being transported to his dialysis appointment. The Regional Facility Consultant #1 told the Unit Manager to contact the Passenger Services Manager to notify her to obtain a statement from Driver #1, an incident report, and their course of action or plan. She further stated she had email communication with transportation (not named) on 2/9/24 at 4:40PM regarding Resident #45 sliding out of his wheelchair while on route to the dialysis center. Regional Facility Consultant #1 explained as corporate support she provided support and direction to make sure regulatory procedures were followed. She indicated it would be her expectation that administration followed up about the incident to ensure procedures were followed. Regional Facility Consultant #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 36	F 689		

indicated she notified the Passenger Services Department that a care event would be put into the system and the Passenger Services Department would need to put in a care event as well. Regional Facility Consultant #1 stated she did not follow up about incident after she provided the facility direction on what information they would need. Regional Facility Consultant #1 indicated she had not contacted the Passenger Services Manager to discuss the details of the investigation or identify what corrective measures were put into place.

Interview with the Director of Nursing Services on 10/14/24 at 3:26PM was conducted. She stated she had reviewed the audio/video footage of the incident involving Resident #45 while he was being transported to the dialysis center. She indicated in the video she observed Resident #45 seatbelt come off and Resident #45 go to the floor of the transportation van. The Director of Nursing Services indicated Driver #1 also continued to transport Resident #45 following the fall while he was seated on the floor of the transportation van.

Interview with the unlicensed Administrator on 10/14/24 at 2:12PM revealed she became aware of the van incident on 2/9/24 through a staff member (name unknown). The unlicensed Administrator stated she did not provide guidance to nursing staff because Resident #45 was not in the building when the fall occurred. She indicated she contacted the Passenger Services Manager on 10/11/24 to get a statement and a copy of the incident report/care event. The unlicensed Administrator confirmed a post-fall investigation was not completed and she had not contacted the Passenger Services Manager to discuss the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 37	F 689		

details of the investigation or identify what corrective measures were put into place.
2. Resident #62 was admitted to the facility on 7/30/24. Review of the admission Minimum Data Set (MDS) dated 8/6/24 revealed Resident #62 was cognitively intact. He was not receiving an anticoagulant. He did not have any impairment to his upper and lower extremities.

Review of Passenger Services Liftgate Use and Patient Safety Check (no date) supplied by the Passenger Services Manager revealed the following:

I. Vehicle Liftgate Use & Safety Checks-
- Always ride liftgate up when getting ready to offload patient
- Ensure liftgate is in the upward position prior to attempting to unload patient
- Do not ride liftgate up or down with the patient on lift

II.Passenger Safety (Unload) -
- Always ride the liftgate up when getting ready to offload patient
- Ensure liftgate is in the upward (level with the floor in the rear of the van) position prior to attempting to unload patient and that the liftgate is level with floor of vehicle
- Get in front of patient and push wheelchair onto liftgate and secure wheelchair by locking wheelchair brakes

Review of Passenger Services Safety Briefing (no date) supplied by the Passenger Services Manager revealed the following:
- To ensure the lift gate is in the "upward position" prior to attempting to offload a patient, always ride the lift gate up after entering from the rear of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 38	F 689		

vehicle.

Review of the video and audio recording (which was center- rear facing) from the hospital owned transportation van dated 8/12/24 revealed the following:

- At 6:08 PM the hospital owned transportation van, driven by Driver #1, returned to the facility with Resident #62's responsible party, Resident #62, and another resident. Resident #62 was observed in his wheelchair with his shoulder securement strap resting across his left upper arm.

- At 6:09 PM to 6:10 PM, Driver #1 disconnected Resident #62's shoulder securement strap and Resident #62 remained in his wheelchair while another resident was being unloaded by Driver #1 via the lift gate.

- At 6:12 PM Driver#1 returned to the hospital owned transportation van and entered from the rear. The lift gate was observed to be on ground level. Driver #1 unsecured Resident #62's wheelchair securement straps from behind.

- At 6:13 PM Driver #1, who was behind Resident #62, was observed pulling Resident #62 backwards towards the rear of the hospital owned transportation van. As Driver #1 crossed the threshold at the rear of the hospital owned transportation van, an audible alarm sounded, and indicator lights lit up red and flashed, which indicated the liftgate was not in the upward position and there was a risk of falling out of the rear of the van. Driver #1 proceeded to fall out of the back of the hospital owned transportation van. She let go of Resident #62's wheelchair as she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 39	F 689		

was falling backwards out of the hospital owned transportation van. Resident #62 was seated in his wheelchair and remained in motion rolling backwards out of the hospital owned transportation van. Driver #1's arm was observed to come up to meet the back of Resident #62's wheelchair as Resident #62 and his wheelchair proceeded to roll off the back of the hospital owned transportation van. Resident #62 continued rolling backwards in his wheelchair and his legs were seen coming up in the air as his chair exited the rear of the hospital owned transportation van and pivoted to where the resident was still seated but facing upwards. Resident #62 then was observed to be slightly unseated from his wheelchair. The wheelchair wheels were observed to be hanging off the back of the hospital owned transportation van. Driver #1 ceased to be in the field of vision. Driver #1 and Resident #62 could be heard yelling/calling out for help. Resident #62's wheelchair wheels were suspended in air and still spinning.

- At 6:14 PM to 6:16 PM facility staff were observed exiting the facility and saw Driver #1 lying on her back on the lift gate on the ground and Resident #62 in his wheelchair tilted to the left resting on Driver #1 and ran back inside to get help. More staff responded and came out to assist. The Unit Manager also responded. Staff were observed standing over Driver #1 and Resident #62. The Unit Manager was observed entering the hospital owned transportation van from the side entrance and walking to the rear of the hospital owned transportation van towards the lift gate. The Unit Manager was observed bending over and grabbing the wheelchair legs while other staff were observed assisting Driver #1 from underneath Resident #62 and his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 40	F 689		

wheelchair. Resident #62's wheelchair was then placed to the left side of the hospital owned transportation van. Driver #1 was observed to stand and stretch. Staff continued to stand as Resident #62 was being assessed. Resident #62 was assisted by staff back to his wheelchair and taken back inside the facility by staff.

An observation was completed on 10/11/24 at 4:55 PM of the Administrator obtaining the measurement of the back of the transportation van where Resident #62 fell backwards in his wheelchair to where he and his wheelchair landed measured three (3) feet and ten (10) inches.

Review of the Care Event (incident report) notification completed by the Passenger Services Manager dated 8/12/24 revealed the following information: Event Description- Driver was unloading patient from wheelchair van. Patient fell out of the wheelchair as driver was exiting patient from vehicle. Driver statement will be sent. Date Occurred: 8/12/24. Incident Location (facility): Hospital System- Health Mobile Medicine. Extent of Harm: Mild Harm. Event Type: Fall.

Review of Driver #1 witness statement dated 8/12/24 read in part: Driver #1 was unloading two patients. Driver #1 unloaded the first patient and took them inside the building. Driver #1 returned to the hospital owned transportation van on the passenger side, where the door was already opened, and unlocked the seatbelt and the wheelchair securement straps. Driver #1 was behind the wheelchair to pull it back to the rear of the hospital owned transportation van not realizing the lift gate was down on the ground and not in the level position. The safety beeper went

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 41	F 689		

off. At that point, Driver #1 was too far back and fell backwards, still holding on to the wheelchair. Driver #1 let go of the wheelchair, so it stayed on the hospital owned transportation van but was tilted back. Driver #1 balanced and held the wheelchair up with her feet as long as she could and called out for help. When Driver #1 strength gave out, the patient and wheelchair fell back onto Driver #1 body breaking the fall. Driver #1 braced his [the resident] upper body with her left arm and hand until help arrived.

An interview with Driver #1 on 10/10/24 at 4:33 PM revealed that she and Resident #62 fell out of the back of the hospital owned transportation van on 8/12/24. Driver #1 explained she went to unload Resident #62 from the hospital owned transportation van after unloading another resident. Driver #1 stated she entered the hospital owned transportation van from the rear and proceeded to unsecure Resident #62 from the wheelchair securement straps from behind. Driver #1 explained she remained behind the wheelchair of Resident #62 and wheeled him backwards towards the lift gate area. Driver #1 voiced she did not realize the lift gate was down. Driver #1 continued to explain while moving Resident #62 towards the lift gate area, walking backwards as she was pulling Resident #62 in his wheelchair backwards, Driver #1 verbalized the alarm/sensor sounded as she crossed the threshold at rear of the van. Driver #1 stated the alarm sound startled her. Driver #1 proceeded to explain she fell backwards out of the hospital owned transportation van taking the wheelchair with Resident #62 with her as she fell. Driver #1 further stated she held the wheelchair with Resident #62 in the air with her feet and hands as long as she could (no timeframe given) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 42	F 689		

hollered for help. Driver #1 expressed she started to fatigue and the wheelchair with the resident fell on top of her as she laid on the lift gate which was at ground level. Driver #1 voiced Resident #62 did not hit the ground, because she had absorbed his fall.

A telephone attempt was made on 10/11/24 at 11:05 AM to speak with the responsible party for Resident #62 without success.

Review of the post fall evaluation completed by the Unit Manager dated 8/12/24 revealed the following: Fall Occurrence: August 12, 2024. Day of Week of Fall Occurrence: Monday. Location of Fall Occurrence: Exterior. Description of Fall Activity: Other. Assistive Device: Lift and Walker. Post Fall Injury: No apparent injury. Post Fall Notification (date/ time/ name): August 12, 2024/ 7:25 PM/ Nurse Practitioner. Outcome of Notification: No new order received. Date/ Time of Family Notification/ Family Contact: August 12, 2024/ 7:25 PM/ onsite discussion with responsible party. Post Fall Analysis (current interventions in place): wheelchair for locomotion, wheelchair locked when not in use, non-skid footwear.

Review of the Unit Manager nursing progress note dated 8/12/24 read in part: Resident #62 observed laying on back on top of Driver #1 on the lift of the hospital owned transportation van with wheelchair laying on top of Resident #62. The lift gate was resting flat on the ground. Driver #1 stated "she broke his fall." Staff came in from the back of the hospital owned transportation van and pulled the wheelchair off of the resident and were able to position resident to where the driver could slide out from under

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 43	F 689		

him. Staff assessed Resident #62 for injury with no apparent injuries noted. Staff assisted Resident #62 to his wheelchair and assessed head for injury, none noted. Nurse Practitioner (NP) was made aware and going to complete full assessment of resident for injury. Responsible party made aware and appreciative of care.

An interview with the Unit Manager was completed on 10/11/24 at 11:34 AM. The Unit Manager stated she was in her office working and a family member or visitor was leaving out of the facility. The Unit Manager proceeded to state the family member or visitor started hollering her name. The Unit Manager responded and ran towards the front entry hallway per the request. The Unit Manager explained when she arrived at the front entrance door, the lift was down on the back entry of the hospital owned transportation van and Driver #1 was lying flat on her back with her feet against the back of the hospital owned transportation van (bumper area), Resident #62 was on top of Driver #1 on his back, the wheelchair was half on top of him/ half under him somehow. The Unit Manager recalled she immediately went to remove the wheelchair from on top of resident. She stated she could not remove the wheelchair from on top of Resident #62, so she went in the hospital owned transportation van through the side entrance to remove the wheelchair from the top angle. The Unit Manager voiced she was able to remove the wheelchair and get it upright inside the hospital owned transportation van. The Unit Manager stated she exited the hospital owned transportation van with the wheelchair through the side entrance. The Unit Manager further stated that she and another nurse quickly assessed Resident #62 for immediate injury so they could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 44	F 689		

get Driver #1 from underneath him and get Resident #62 lying flat. The Unit Manager and another nurse assisted Driver #1 from underneath Resident #62. The Unit Manager assessed Resident #62 which included movement of all extremities, skin assessment (abrasions, bruising or red marks), and assessing for pain. The Unit Manager recalled Resident #62, and Driver #1 were able to verbalize that Resident #62 did not hit his head during the incident. The Unit Manager and other staff were able to provide support to Resident #62 and assist him with standing so he could transfer to his wheelchair. The Unit Manager had a staff person assist Resident #62 back into the facility. The Unit Manager voiced the NP was onsite and assessed Resident #62 after the incident. The Unit Manager did not recall Resident #62 sustaining any injuries. Resident #62's responsible party was onsite during the incident, but the Unit Manager could not recall if Resident #62's responsible party witnessed the incident.

A telephone interview was completed with the Passenger Services Manager on 10/11/24 at 1:56 PM. The Passenger Services Manager recalled the incident involving Resident #62. The Passenger Services Manager stated she was contacted by Driver #1 at some point after the incident. The Passenger Services Manger did not recall the exact time she was notified of the incident. Driver #1 expressed that she forgot to place the lift gate in the upward position while unloading a resident. The Passenger Services Manager stated the video footage in the hospital owned transportation vans had both audio and visual components. The Passenger Services Manager communicated when she reviewed the video footage, the lift gate was not in the upward

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 45	F 689		

position and Driver #1 and Resident #62 fell out the back of the hospital owned transportation van onto the lift gate. The Passenger Services Manager recalled seeing the red light flash but did not recall hearing the alarm sound when she reviewed the video footage. The Passenger Services Manager stated Driver #1 was provided re-education on what steps should have been followed when unloading a patient, inclusive of lift gate use, via telephone call on 8/12/24 due to the Passenger Service Manager being out of the office. An in-person coaching, counseling and re-education session on the process for unloading a patient, inclusive of lift gate use, was completed by the Passenger Service Manager on 8/15/24.

A telephone attempt was made on 10/11/24 at 11:15 AM to speak with the previous Director of Nursing without success.

An interview completed on 10/14/24 at 11:59 AM with Nurse #3 revealed a family member returned inside the building and hollered that help was needed outside. Nurse #3, who was sitting at the nurses' station, and other staff responded. Driver #1 was lying on the lift which was all the way to the ground, Resident #62 was on top driver, and Resident #62's wheelchair was tilted backwards and hung up in the mechanical parts of the lift. Nurse #3 communicated Resident #62 was truly resting on top of driver. Nurse #3 assisted with Resident #62 returning him inside of facility and to his room. The nurse recalled the Unit Manager completed a post fall assessment and informed the NP. Nurse #3 recalled Resident #62 did not have any visible marks or abrasions. Resident #62 did not verbalize any complaint or pain. Nurse #3 stated that Resident #62 was in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 46	F 689		

pleasant mood after the incident and requested staff to change his clothes due to wearing paper scrubs from his appointment.
Review of the Nurse Practitioner assessment dated 8/12/24 read in part: Patient seen today due to recent fall. Patient had an incident of a fall when he was being transported. Patient moving all extremities at baseline. No visible signs of injury. Denies any complaints. Notes that he is hungry and ready for dinner. Assessment and Plan: Ambulatory dysfunction- physical therapy and occupational therapy. Fall precautions- last fall noted on 8/12 when wheelchair tipped backwards on transport van, but patient sustained no injuries.

An interview with the Nurse Practitioner (NP) was completed on 10/14/24 at 10:50 AM. The NP stated she was aware of the incident involving Resident #62's fall out of the hospital owned transportation van. The NP explained she was onsite on 8/12/24 but was not certain if the incident occurred prior to her arrival or when she came out of her office. The NP recalled Resident #62 was back in his room sitting in his wheelchair when she visited him. The NP verbalized she spoke with Resident #62 to determine if he was at his baseline and had any complaint of pain or injury. The NP stated Resident #62 was alert, she was able to determine there was no notable change in orientation (at baseline resident had some confusion), and Resident #62 was able to describe the incident. Resident #62 was able to move all extremities while sitting in his wheelchair. The NP stated she did not have the resident stand. However, he was able to lift legs and push legs against her without any problems. Same with his arms. He had no abrasions on his upper or lower extremities, and no open areas/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 47	F 689		

abrasions noted to his head area. The NP recalled Resident #62 had no complaints of pain or discomfort.

An interview with the Director of Nursing Services was completed on 10/14/24 at 3:05 PM. The Director of Nursing Services stated she was notified of the event a few days later (uncertain of actual date). She explained she was made aware of transport moving someone out the back of the hospital owned transportation van and both resident and driver fell out the back of the hospital owned transportation van due to the lift gate not being in the appropriate placement. The Director of Nursing Services received email notifications after the event of in-servicing/ re-education and training being provided to Driver #1. The Passenger Services Manager completed the plan of correction following the fall from the hospital owned transportation van involving Driver #1 and Resident #62. The Director of Nursing Services was uncertain of the collaboration with facility administrative staff regarding the incident. The Director of Nursing Services explained the process after an incident should include assessment of the resident by a licensed professional, a root cause analysis, and have a plan of correction in place to prevent any further incidents, collaboration between transportation staff and facility administrative staff (if the incident involved a hospital owned transportation van). The Director of Nursing Services was not aware if the facility investigated the root cause and implemented interventions to prevent the incident from happening again.

An interview was completed with the unlicensed Administrator on 10/14/24 at 3:51 PM. The unlicensed Administrator communicated Driver #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 48	F 689		

did not adhere to the safety mechanism on the lift gate. The alarm sounded and the light flashed. The Administrator continued to communicate Driver #1 did not place the lift gate in the right position when unloading Resident #62 and this caused the incident to occur.

The unlicensed Administrator was notified of immediate jeopardy on 10/11/24 at 7:17 PM.

The facility provided the following credible allegation of immediate jeopardy removal plan:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

1. On 2/09/24 Resident #45 was at the dialysis clinic when the Administrator was notified by a staff member that Resident #45 experienced a fall while in van transport. Driver #1 did not notify the facility administrator nor her supervisor, the Passenger Services Manager, about the accident.

On 2/09/24 the Administrator contacted the Passenger Services Manager to begin an investigation and require education of Driver #1.

On 2/09/24 Driver #1 was transporting Resident #45 to a dialysis appointment in the Hospital system transportation van. Driver #1 put on the brakes suddenly and Resident #45 slid from his wheelchair onto the floor. The Passenger Services Manager conducted the investigation and completed the review of the video revealed that the lap belt and shoulder harness had excessive slack and did not appear to be snug to the resident as per manufacturer's instructions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 49	F 689		

Driver #1 went to Resident #45 and attempted to pick up Resident #45 and placed him back in his wheelchair but was unsuccessful and he slid back to the floor where he was in a seated position. Driver #1 returned to the driver's seat, and then drove the van to the Dialysis Clinic, with Resident #45 on the floor of the van. The Dialysis Clinic is approximately 1.2 miles from the facility.

On 2/10/24, Fleet Services inspected the van post incident and found no malfunctions of the securement system.

On 10/13/24, the facility administrator interviewed the Passenger Services Manager, and she stated that all drivers complete a daily pre-trip audit checklist which includes checking securement straps (lap belt and shoulder harness) for signs of fraying, malfunctioning buckles and wheelchair tie downs before the drivers' first trip of the day. Driver #1 did not report any pre-trip malfunctioning of the van securement system to the Passenger Services Manager on 2/9/24.

The Passenger Services Manager provided documentation to validate that Driver #1 received related education on the following policies and procedures: "General Safety"," Motor Vehicle Accidents & Emergency Reporting Procedures", "Expectations of Passenger Services Drivers", "Proper Transport Loading and Unloading Wheelchair Patients" and "Mobile Cellular Device" to the facility administrator. Documentation of training and acknowledgment was signed on 2/13/24.

On 3/2/24 Driver #1 was re-educated again on the following Policies and procedures: "General Safety"," Motor Vehicle Accidents & Emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 50	F 689		

Reporting Procedures", "Expectations of Passenger Services Drivers", "Proper Transport Loading and Unloading Wheelchair Patients" and "Mobile Cellular Device" and documentation of training was provided to the facility administrator. Documentation of training and acknowledgment was signed on 3/2/24.

On 10/14/24, the Passenger Services Manager notified the facility administrator that on 2/12/24 and 2/13/24, the Lead Driver accompanied Driver #1 on transportation routes and provided one-to one re-training with return demonstration as assigned by the Passenger Services Manager which included manufacturer's instructions for securing the lap belt, shoulder harness and cease driving when resident is not securely seated or when resident has fallen out of wheelchair. Driver #1 reported back to work on 2/12/24. Documentation of training and acknowledgment was signed on 2/13/24 by Driver #1.

2. On 8/12/24 Driver #1 returned to the facility from medical appointments with two residents. Driver #1 offloaded one resident and returned the resident back into the facility. Resident #62 was still on the van waiting to be offloaded by Driver #1. Driver #1 unlocked the seat belt and unbuckled the hooks from the wheelchair. When Driver #1 began to pull resident off the van onto the liftgate the safety alarm alerted, indicating an unsafe lift position. Driver #1 stated that she was not in position to stop while in motion and Driver #1 fell off the van onto the grounded lift gate. Driver #1 did not realize that she did not have the liftgate in the correct position which caused the incident to occur. Resident #62, while remaining in wheelchair, fell onto Driver #1. Resident #62 was immediately assessed by a licensed nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 51	F 689		

and no apparent injuries were noted. On 8/13/24, the Physician assessed resident for injury related to the incident and no injuries were noted.

Passenger Services Manager provided the following employee action and education for Driver #1 on 8/12/24. Driver #1 continued to transport SNF residents without interruption after 8/12/24 incident.

Education and actions were validated by the facility administrator on 9/11/24:

8/12/24: Driver #1 reeducated by Passenger Services Manager on the wheelchair van lift gate which included offloading resident from van Driver #1 acknowledged education of "Lift gate Use and Patient Safety." Per manufacturer's instructions

8/13/24: Vehicle taken out of service to have liftgate evaluated. Fleet Service found the liftgate was functioning with no concerns and van was put back in use.

8/16/24: Spot Check/Observation/Retraining conducted by Lead Driver II (the senior driver and provides education and training for drivers). Pre-trip inspections are to be conducted daily by Driver assigned prior to driving patients in van. Lead Driver II will randomly audit all drivers pre-trip inspections.

8/19/24: Competency skills checklist document completed for Driver #1 by Lead Driver II.

Competency skills checklist includes but not limited to the following for all Mobile Medical Services Drivers:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 52	F 689		

Use of Two Way Radio
Knows how to perform pre trip inspection checklist and able to note any vehicle issues
Knows how to report vehicle accident within app
Liftgate Use
Checked Liftgate lights
Check lift up and down button
Run safety check on liftgate before using for passengers
Demonstrated Use of Manual pump for liftgate
Vehicle/Liftgate Operations
Demonstrates and discuss concepts of "safety" always
Evaluates loading and unloading zones for hazards
Opens and properly secures van doors
Assures level landing area and clear path of operation for lift
Assures liftgate is in the "up position" prior to offloading wheelchair patient
Driver completes a visual inspection of resident/patient wheelchair (excessive items in chair, leg lifts, functioning brakes, rolls freely)
Driver identifies weight limit of the lift
Put wheelchair patient on the lift in the forward position or per the lift manufacturers recommendation
Secured wheelchair on lift.
Pushed wheelchair onto van and locked wheelchair brakes
Correctly operated lift
Driver returns lift control to appropriate location
Wheelchair Securement and Patient Restraint
Communicated with patient what you are doing (reaching across them to place shoulder harness and lap belt on)
Secured back straps
Confirms floor anchor position for straps is within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 53	F 689		

the width of the wheelchair frame
Pulls straps straight out to chair and attaches to appropriate anchor point on the wheelchair frame
Does not allow strap to twist
Allows straps to retract and manually tightens them by twisting the ratchet knob
Placed lap strap around the patient and locked it in place
Secured front straps
Identifies lap or lap/shoulder belt system
Assures restraint belt is against patient and does not have slack
Assures shoulder strap does not twist
Positions lab belt low on torso at area of pelvic arch (hips)
Positions buckle on the right side
Positions shoulder belt over shoulder and not against neck
Positions shoulder strap at level with or higher than shoulder
Ensures that straps not compromised with blankets that are over patients
Watchful of any items that could prevent a safe patient securement
Incident & Medical Reporting
Correctly stated how an Incident is Reported Involving a Patient
Understands process of notification and documentation of any incident

All residents who use wheelchair transportation services for medical appointments are at risk of experiencing an adverse outcome as a result of this deficient practice. Residents who experienced transport by the transportation service within 30 days were interviewed on 10/12/24 and 10/13/24 by the following members from the Interdisciplinary team (IDT) for review and discussion: Activities Director, Rehab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 54	F 689		

Manager, Licensed Practical Nurse/Unit Coordinator and Resident Liaison. Interviews were related to any incidents or accidents while in transport occurred. No evidence of any additional deficient practice during transport was reported. For current residents who were not able to be interviewed, the assigned transportation companions were interviewed 10/12/24 and 10/13/24 and no evidence of any additional deficient practice during transport was reported.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

The facility will take immediate action by informing hospital system transportation services to remove Driver #1 from transporting facility residents to any external appointments, Effective at 8:40 pm on 10/11/24.

Beginning 10/12/24, the Passenger Services Manager will conduct in person training with all transportation drivers assigned to the facility, including return demonstration of offloading and securement of passengers. The training will include the Safety Briefing slide (providing a visual of the correct position for the liftgate); the Passenger Services Liftgate Use; Patient Safety Check requirements. Training and Education will also include offloading residents from the van and proper securement with the wheelchair van wheelchair and resident securement system according to the manufacturer's instructions. Competency skills checklist was completed for all drivers and continues annually upon orientation.

Any transportation drivers who do not receive the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 55	F 689		

education by 10/12/24 (due to FMLA, leave, etc.) will be required to complete education prior to working a scheduled shift. All newly hired drivers assigned to the facility will be required to complete this training and education upon hire and all drivers will be required to complete this education annually.

Beginning 10/12/24, the Passenger Services Manager will provide documented evidence of training and education of all assigned drivers to the Administrator and Director of Nursing.

Alleged Date of Immediate Jeopardy Removal: 10/15/24

The facility's immediate jeopardy removal plan was validated on 10/16/24 by the following:

The facility provided documentation to support their corrective action plan including education provided by the Passenger Services Manager to the current drivers who operate the hospital owned transportation vans. The documentation was reviewed for each driver and each driver was found to have received the education and it was documented each driver provided return demonstration to the Passenger Services Manager. Driver #2 demonstrated the correct method to secure a wheelchair with a resident into the hospital owned transportation van using the securement system. Driver #2 demonstrated the correct procedure to remove a resident from the hospital owned transportation van including riding the hospital owned transportation van lift gate to the back of the hospital owned transportation van and entering the hospital owned transportation van from the rear. Interviews were conducted with a sample of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 56 drivers, and they were able to report the pre-trip safety checklist, securing a wheelchair passenger into the hospital owned transportation van, and safe removal of a wheelchair passenger from the hospital owned transportation van. The facility's date of Immediate Jeopardy removal of 10/15/24 was validated.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to label the gastrostomy feeding formula with the flow rate	F 693	F693 On 10/7/24, the assigned nurse confirmed that Resident #40 received the tube	11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 693	Continued From page 57 and the time the formula was hung for 1 of 1 resident reviewed for tube feeding (Resident #40). The findings included: Resident #40 was admitted to the facility on 07/29/22 with diagnoses which included anoxic brain injury, tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe or trachea), persistent vegetative state, percutaneous endoscopic gastrostomy (medical procedure where a tube is inserted through the abdominal wall and into the stomach) tube placement. The quarterly Minimum Data Set (MDS) assessment dated 09/20/24 revealed Resident #40 was rarely/never understood and rarely/never made decisions. The nutritional approach while a resident was via feeding tube. Review of Resident #40's care plan revealed the resident required a permanent feeding tube for the provision of nutrition. The goal for Resident #40 was to maintain adequate nutritional and hydration status as evidenced by stable weight, and no indicators of malnutrition or dehydration. Review of a physician order dated 11/16/23 revealed an order for Resident #40 to receive continuous feeding formula infused at 45 milliliters (ml) per hour via pump infusion. Flush enteral tube with 30 ml of water every hour via pump. The manufacturer's information stated prefilled containers can hang safely for up to 48 hours when clean technique and only one new feeding	F 693	feeding based on physician orders. On 11/2/24, Nurse #2 was re-educated by the Director of Nursing to label tube feeding with the name of the resident, date and time tube feeding was placed, the rate, and the name or initials of the nurse. On 11/8/24, Nurse #3 was re-educated by the Director of Nursing to label tube feeding with the name of the resident, date and time tube feeding was placed, the rate, and the name or initials of the nurse. On 10/15/24 the Director of Nursing observed all tube feeding labels to assure proper labeling with the name of the resident, date and time tube feeding was placed, the rate, and the name or initials of the nurse. On 10/29/24, the Director of Nursing re-educated all nurses to label tube feeding with the name of the resident, date and time tube feeding was placed, the rate, and the name or initials of the nurse. Any staff members who do not receive the training by 11/13/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 11/7/24, the Director of Nursing and/or Charge Nurse will audit labeling of tube feeding 2 times a week for 12 weeks. Any identified issues will be corrected at that time. Results of the auditing will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 693	Continued From page 58 set is used. An observation conducted of Resident #40 on 10/07/24 at 12:57 PM revealed the resident's tube feeding formula labeling information was written on a cloth surgical tape which only contained the date, name of resident and initials of nurse. There was no information about the time it was hung and flow rate based on the order. The pump was running at 45 ml per hour. An interview with Nurse #2 was conducted on 10/07/24 at 1:18 PM revealed the feeding formula was hung by the nurse working on night shift. Nurse #2 verbalized the label should indicate the name of the resident, date and time tube feeding was placed, the rate, and the name or initials of the nurse. An interview with Nurse #3 on 10/11/24 at 1:09 PM revealed she worked from 7:00 PM to 7:00 AM on 10/06/24 and confirmed taking care of Resident #40. Nurse #3 said she had been labeling tube feedings as observed and nobody had said anything about what she's been doing. An interview conducted with the Interim Director of Nursing (DON) on 10/11/24 at 4:20 PM revealed the facility nurses were aware of what needed to be done. The Interim DON further stated that the facility nurses knew the policy. The Interim DON verbalized staff do things to finish quicker. An interview conducted with the unlicensed Administrator on 10/16/24 at 4:45 PM revealed she was still investigating the findings. The unlicensed Administrator verbalized that anytime there was tube feeding, it should be labeled	F 693	shared with the Administrator weekly and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The Director of Nursing is responsible for this corrective action. Plan of Correction Date is 11/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 693	Continued From page 59 appropriately.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to post cautionary and safety signage indicating the use of oxygen outside resident rooms for 3 of 3 sampled residents reviewed for respiratory care (Resident #40, Resident #41 and Resident #56). The findings included: 1. Resident #40 was admitted to the facility on 7/29/22 with diagnosis of tracheostomy (a hole that surgeons make through the front of the neck and into the windpipe or trachea). The quarterly Minimum Data Set (MDS) assessment dated 9/20/24 revealed Resident #40 was rarely/never understood and rarely/never made decisions. The respiratory treatment while a resident was oxygen therapy. A physician's order for Resident #40 dated 10/10/24 revealed to keep the resident's oxygen saturation above 90% and wean to maintain	F 695	F695 Resident #40, Resident #41, and Resident #56 experienced no harm by this practice. On 10/25/24, the Director of Nursing and Nurse Educator placed the Oxygen in Use signage on the doors of Resident #40, Resident #41, and Resident #56. On 11/8/24, the facility developed a process to prevent this event from reoccurring. Every room in the facility will have an Oxygen in Use sign as resident rooms do change and some residents with oxygen visit other resident□s rooms. Beginning 10/29/24, the Director of Nursing re-educated all nurses regarding the new oxygen signage process. Beginning 11/2/24, the Director of Nursing re-educated all nurse aides regarding the new oxygen signage process. Any staff members who do not receive the training	11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 695	Continued From page 60 saturation of >90% via tracheostomy collar. During an observation on 10/07/24 at 12:55 PM, no signage for oxygen use was found anywhere near Resident #40's room entrance. Resident #40 was observed on oxygen via tracheostomy collar at 5 liters per minute. An interview conducted with the Interim Director of Nursing (DON) on 10/11/24 at 4:21 PM revealed the facility consolidated all the residents to halls 400, 500, and 600. Resident #40 moved from 300 hall to 400 hall last week. The Interim DON expressed that before the transfer occurred, the staff went around the facility to ensure oxygen signs were in place at each resident's room requiring oxygen use. The Interim DON verbalized whoever nurse admitted a resident requiring oxygen should make sure necessary items were prepared. An interview conducted with the unlicensed Administrator on 10/16/24 at 4:43PM revealed staff had moved all residents to halls 400, 500 and 600 on 10/04/24. The unlicensed Administrator further revealed staff did not have the chance to make sure cautionary oxygen signage was placed in all residents' rooms that were ordered oxygen. All residents that receive oxygen should have a cautionary signage. 2. Resident #41 was admitted to the facility on 8/2/22 with a diagnosis that included respiratory failure and seizure disorder. The annual Minimum Data Set (MDS) assessment dated 8/9/24 indicated Resident #41 was severely cognitively impaired, received tracheostomy care (a hole that surgeons make through the front of the neck and into the	F 695	by 11/13/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 11/8/24, the Director of Nursing and/or the Charge Nurse will monitor the doorframes on all units and common areas for the presence of the signs weekly for 12 weeks. Any identified issues will be corrected at that time. Oxygen in use signs will be placed in all resident common areas such as the beauty shop, day room, activity rooms, lobby and rehab gym. Results of the monitoring will be shared with the Administrator weekly and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The Director of Nursing is responsible for this corrective action. Plan of Correction Date is 11/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 695	Continued From page 61	F 695		

windpipe or trachea) and oxygen (O2) therapy.

Review of physician order dated 10/1/24 indicated a modification. The order sated oxygen adult low flow nasal cannula/O2 at 5 liters per minute (lpm) continuous with 28% humidification via trach for hypoxia prevention.

Observation on 10/8/24 at 9:19AM revealed Resident #41in his bed receiving oxygen via tracheostomy. There was no cautionary signage indicating the use of oxygen on Resident #41's door.

An observation of Resident #41 on 10/9/24 at 10:45AM revealed him receiving oxygen via tracheostomy. There was no cautionary signage indicating the use of oxygen on Resident #41's door.

Interview and observation with Nurse #6 on 10/9/24 at 2:54PM stated she believed it would be the responsibility of the nurse to place oxygen signage on residents' doors. She stated it should be done upon admission or when the resident received an order to use oxygen. Upon observation of Resident #41's room she stated the resident did use oxygen and did not have signage identifying the use of oxygen.

Interview and observation with the Interim Director of Nursing on 10/9/24 at 2:58PM revealed it was the responsibly of the admitting nurse or the responsibility of the nurse working when the resident obtained an order for O2 to apply cautionary signage. She further revealed oxygen signage was kept in the oxygen storage room. Upon observation of Resident #41's room the Interim Director or Nursing indicated there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 695	Continued From page 62	F 695		

was not signage and there should have been signage. She stated the error occurred with they recently moved several residents to consolidate halls. The signage must not have followed the residents.

An interview conducted with Unlicensed Administrator on 10/16/24 at 4:43PM revealed staff had moved all residents to halls 400, 500 and 600 on 10/04/24. The Unlicensed Administrator further revealed staff did not have the chance to make sure cautionary oxygen signage was placed on all resident rooms that were ordered oxygen. All residents that receive oxygen should have cautionary signage.

3. Resident #56 was admitted to the facility on 9/13/24 with a diagnosis that included acute respiratory failure with hypoxia.

Review of the admission MDS assessment dated 9/13/24 revealed Resident #56 was moderately cognitively impaired and had oxygen in use upon admission.

Review of Resident #56 physician order dated 10/1/24 stated oxygen adult low flow nasal cannula 3-7. May increase flow rate to 3 to keep saturation of peripheral oxygen (spO2) greater than 90% and wean as tolerated to maintain spO2 at 90% or greater.

Observation of Resident #56 on 10/8/24 at 8:48AM revealed him to be seated in his wheelchair with nasal cannula applied with oxygen running. There was no cautionary signage to Resident #54's room identifying oxygen was in use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 695	Continued From page 63 Interview and observation with Nurse #6 on 10/9/24 at 2:54PM stated she believed it would be the responsibility of the nurse to place oxygen signage on residents' doors. She stated it should be done upon admission or when the resident received an order to use oxygen. Upon observation of Resident #56's room she stated the resident did use oxygen and did not have signage identifying the use of oxygen. Interview and observation with the Interim Director of Nursing on 10/9/24 at 2:58PM revealed it was the responsibly of the admitting nurse or the responsibility of the nurse working when the resident obtained an order for O2 to apply cautionary signage. She further revealed oxygen signage was kept in the oxygen storage room. Upon observation of Resident #56's room, the Interim Director or Nursing indicated there was not signage and there should have been signage. She stated the error occurred with they recently moved several residents to consolidate halls. The signage must not have followed the residents. An interview conducted with Unlicensed Administrator on 10/16/24 at 4:43PM revealed staff had moved all residents to halls 400, 500 and 600 on 10/04/24. The Unlicensed Administrator further revealed staff did not have the chance to make sure cautionary oxygen signage was placed on all resident rooms that were ordered oxygen. All residents that receive oxygen should have cautionary signage.	F 695		
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		11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 761	Continued From page 64 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, record review,and pharmacist and staff interviews, the facility failed to label and date an opened vial of Purified Protein Derivative (PPD) stored in 1 of 1 medication room refrigerator reviewed for medication storage. The findings included: A review of the manufacturer's recommendation for Purified Protein Derivative (PPD) storage, PPD vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.	F 761	F761 No residents were harmed because of the undated Purified Protein Derivative (PPD) solution. On 10/10/24 the nurse discarded the undated PPD vial. On 10/11/24 the Pharmacy Consultant inspected the medication refrigerator. There were no other undated opened liquids observed. On 10/29/24, the Director of Nursing re-educated all nurses and medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 761	Continued From page 65 An observation was completed of the medication room refrigerator with the Interim Director of Nursing (DON) on 10/10/24 at 10:03 AM revealed an opened PPD vial in a plastic pouch. The affixed sticker had a dispensed date of 08/2/24. There was no open date or discard date marked on the box/pouch. During an interview with the Interim DON on 10/10/24 at 10:07 AM, the Interim DON verbalized the nurses, and the pharmacist had access to the medication room refrigerator. The Interim DON verbalized she was surprised to see the opened and unlabeled PPD solution had not been discarded. The Interim DON verbalized the pharmacist finished checking the cart and medication room refrigerator last on 10/07/24. The Interim DON removed the PPD solution in question. An interview with the Pharmacist on 10/11/24 at 1:19 PM revealed the Pharmacist inspected the medication room, treatment carts, and medication carts monthly. Last time she conducted her inspection was 10/07/24. The Pharmacist stated that any vial, once opened, should be labeled with open and discard date.	F 761	aides on proper labeling of medication when opened. Any Nurse or Medication Aide who do not receive the training by 11/13/24 (due to FMLA, leave, etc.) will be required to complete training prior to working a scheduled shift. This education will continue to be required annually and during new hire orientation. Beginning 11/3/24, the Night Shift nurse will check all biologicals for dates opened on the medication carts and in the storage refrigerators nightly and discard any improperly labeled items. Beginning 11/8/24, the Director of Nursing and/or Charge Nurse will monitor the medication carts, storage areas, and refrigerators weekly for 12 weeks for unlabeled biologicals. Any identified issues will be corrected at that time. Results of the monitoring will be shared with the Administrator weekly and with Quality Assurance and Performance Improvement (QAPI) monthly for a period of 90 days at which time frequency of monitoring will be determined by the QAPI Committee. The Director of Nursing is responsible for this corrective action. Plan of Correction Date is 11/15/24	
F 837 SS=C	Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing	F 837		11/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 837	Continued From page 66 body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). This REQUIREMENT is not met as evidenced by: Based on record review, and staff and the Executive Director of the NC Board of Nursing Home Administrators interviews, the facility failed to have a licensed Administrator in place to oversee the daily staff and resident operations of the skilled nursing facility. This failure had the potential to affect all residents residing in the facility. The findings included: An interview was completed with the Executive Director of the NC Board of Nursing Home Administrators on 10/23/24 at 11:12 AM. The Executive Director of the NC Board of Nursing Home Administrators was notified on 10/21/24 by the unlicensed Administrator via telephone call that her license had expired on 9/30/24. The Executive Director of the NC Board of Nursing Home Administrators explained the unlicensed	F 837	F837 On 10/21/24, the unlicensed Administrator was issued a temporary license by the North Carolina Board Nursing Home Administrators. On 12/13/24, the Administrator□s temporary license will expire. The application for the permanent Administrator□s license was completed on 11/5/24. The Administrator is awaiting the North Carolina Board of Nursing Home Administrator Board's decision to issue a permanent Administrator's license. This Board Meeting is scheduled for 12/3/24. Beginning 10/21/24, all licensing information and credentials will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001

(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 837	Continued From page 67 Administrator was being honest and stated she forgot to renew her license at the end of September. The Executive Director of the NC Board of Nursing Home Administrators verbalized the unlicensed Administrator's license was originally issued on 12/2/22 and expired on 9/30/24. The Executive Director of the NC Board of Nursing Home Administrators communicated a temporary license was issued to the unlicensed Administrator on the afternoon of 10/21/24 which will expire on 12/13/24. A telephone interview with the unlicensed Administrator was completed on 10/24/24 at 11:09 AM. She explained she was under the impression the deadline for administrator license renewal was extended due to Hurricane Helene. The unlicensed Administrator stated she reached out to the NC Board of Nursing Home Administrators and they informed her she was not eligible for the extension due to not being in an affected area. The unlicensed Administrator stated that she had to reapply for her Administrator license and was granted a temporary license effective 10/21/24 with an expiration date of 12/13/24. A telephone interview was completed on 10/24/24 at 1:45 PM with the Vice President (VP) for Advocate Health which includes oversight for the nursing home administrators across the hospital healthcare system. The VP for Advocate Health stated the unlicensed Administrator telephoned him on 10/21/24 to inform him her license had expired. He further stated the temporary license paperwork was completed the afternoon of 10/21/24. The VP of Advocate Health communicated ultimately the Administrators were responsible for making sure their license	F 837	monitored in the electronic system. The Administrator will send licensure validation to the Vice President, who will monitor for compliance. Beginning 10/21/24, the Vice President and/or designee will audit licensure validation monthly, until permanent Administrator's license is issued. All newly hired Administrators will be required to have their active NHA license verified by Human Resources Department and validated by the Vice President of Continuing Health through the State Board for Nursing Home Administrator's portal. Results of the monitoring will be shared with Quality Assurance and Performance Improvement (QAPI) until the permanent Administrator's license is issued and then will be shared with QAPI bi-annually. The Vice President is responsible for this corrective action. Plan of Correction Date is 11/15/24	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	**625 BETHANY CHURCH ROAD ALBEMARLE, NC 28001**

(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 837	Continued From page 68 remained current. The VP of Advocate Health voiced moving forward he and his administrative staff will work with the current Administrators to ensure that issue dates and expiration dates were obtained and reviewed so that all Administrators have an active license within the hospital healthcare system's skilled nursing facilities.	F 837		