

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345333	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/27/2024
NAME OF PROVIDER OR SUPPLIER  Abbotts Creek Center		STREET ADDRESS, CITY, STATE, ZIP CODE 877 Hill Everhart Road Lexington, NC 27295	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45276</b></p> <p>Based on record review, observation, and staff interviews, the facility failed to develop a comprehensive person-centered plan to address anticoagulant, insulin, and antidepressant use for 1 of 15 residents reviewed for comprehensive care plans (Resident # 18).</p> <p>The findings included:</p> <p>Resident #18 was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure with hypoxia, atrial fibrillation, diabetes mellitus, and major depressive disorder.</p> <p>A review of the physician's orders dated 08/12/24 revealed the following orders:</p> <ul style="list-style-type: none"> <li>- Insulin Lispro (1 unit dial) Subcutaneous Solution Pen Injector 100 unit/milliliter Inject as per sliding scale subcutaneously four times a day for diabetes mellitus</li> <li>- Insulin Glargine Subcutaneous Solution Inject 10 units subcutaneously in the morning for diabetes mellitus</li> <li>- Sertraline HCL Oral Tablet 50 milligrams Give 1 tablet via PEG Tube one time a day for depression</li> <li>- Apixaban Oral Tablet 5 milligrams Give 1 tablet via PEG Tube two times a day for atrial fibrillation</li> </ul> <p>A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #18 was cognitively impaired, diagnosed with depression and received antidepressant medication for the seven days of the look back period. The MDS further revealed Resident #18 was diagnosed with diabetes and received insulin six days during the look back period. The MDS also revealed Resident #18 was diagnosed with atrial fibrillation and was marked yes for anticoagulant use during the look back period.</p> <p>A review of the care plan dated 08/18/24 revealed that Resident #18 did not have a person-centered care plan that addressed anticoagulant use, insulin use, and antidepressant use.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 09/27/24 at 12:37 PM an interview was conducted with the MDS Nurse, and she stated the admitting nurse was responsible for initiating a baseline care plan and then the MDS nurse built the comprehensive care plan from the baseline care plan. The MDS Nurse stated a traveling MDS Nurse completed Resident #18's admission MDS assessment.</p> <p>Attempts to reach the traveling MDS Nurse via telephone were unsuccessful.</p> <p>An interview was conducted with the Director of Nursing (DON) and Administrator on 09/27/24 at 12:29 PM and the DON stated the admitting nurse was responsible for the initiation of Resident #18's baseline care plan and then the MDS Nurse built on to the baseline care plan when he/she completed the comprehensive care plan. The DON stated the use of anticoagulant medication, insulin, and antidepressant medication should have been picked up and care planned on admission.</p>		

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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20670</p> <p>Based on record reviews and staff interviews, the facility failed to arrange home health services upon discharge for 1 of 4 sampled residents (Resident #54) reviewed for discharge planning.</p> <p>Findings included:</p> <p>Resident #54 was admitted to the facility on [DATE] with diagnosis of paroxysmal atrial fibrillation, dementia, and congestive heart failure.</p> <p>The admission Minimum Data Set assessment dated [DATE] indicated Resident #54 was severely cognitively impaired.</p> <p>The physician's order dated 5/29/24 documented Resident #54 was to discharge home on 5/31/24. The order revealed the resident would need a hospital bed related to her inability to transfer or lay flat. Resident would need a home health agency (HHA) for ADL (activities of daily living) assistance; home health nursing for medication management; physical therapy (PT) and occupational therapy (OT) to evaluate and treat; and a social worker (SW) for the community.</p> <p>The review of the Discharge Plan Documentation dated 5/30/24 completed by the facility's former Social Worker indicated Resident #54 was to be discharged home with her family, home health services and Hospice starting 5/31/24. A hospital bed was ordered for delivery to resident's home on 5/31/24.</p> <p>The Assessment and Plan included in the physician's Discharge Summary dated 5/31/24</p> <p>indicated Resident#54's family would assist the HHA with the resident's ADL care at home. If the resident decided to participate with PT, the HHA would also provide PT if the resident was willing to participate.</p> <p>During an interview on 9/25/24 at 3:39 p.m., the Business Office Manager revealed the SW, who conducted the discharge planning at the time of Resident #54's discharge, no longer worked at the facility. She stated that after searching the resident's medical records and the facility's records, there was no documentation available indicating the SW made a referral for home health assistance for Resident #54. She further revealed the facility contacted the two home health providers the facility typically made referrals to and was informed they had no referrals for this resident.</p> <p>On 9/25/24 at 4:51 p.m., a telephone interview was conducted with the former Social Worker who was able to recall completing discharge planning with Resident #54 and her family member. She stated she made the referral for home health for the resident but could not recall if referral was made via email or during an onsite visit.</p> <p>During an interview on 9/27/24 at 4:22 p.m., the Administrator acknowledged the prior Social Worker failed to follow through with home health services for Resident #54.</p>		