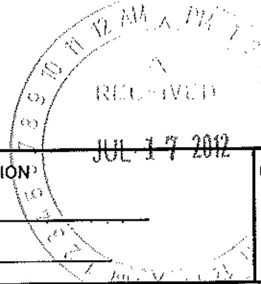
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 07/05/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345378	A. BUILDING ______ B. WING ______	06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCKINGHAM MANOR	804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS F 309 D amended - resent statement of deficiencies on 7/3/12, 7/5/12.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to assess and recognize pain during wound care treatment for 1 of 1 sampled resident (Resident #170). Findings included: Resident #170 was admitted into the facility on 5/17/12. Diagnoses included an Unstageable Ulcer. The admission minimum data set completed on 5/24/12 indicated Resident #170 mental status was cognitively intact. A pain assessment was conducted with no pain present on admission. The care plan initiated on 5/30/12 identified an unstageable sacral ulcer, with approaches and interventions to care for. A review of the medication administration record for May 2012 - June 2012 revealed no scheduled, or as needed pain medications.	F 309	F-309 Provide Care Services for the Highest Well-being (pain-assessment during dressingchang) SS=D Requirement: Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment. 1. Corrective action for those affected by deficient practice. Resident #170 received standing order for Tylenol on 06/19/2012. Resident also received additional dosage change to Tylenol order on 06/20/2012. Resident was examined and assessed for pain and pain management approaches by In-house facility Vohra Wound Specialist 06/25/2012; no changes to above received orders. Vohra Wound Physician will examine resident weekly during rounds. Nurse# 1 received in-service training by DON on 06/22/2012 with focus on assessing pain, not only prior to dressings change to include after dressing change. 2. Corrective action for residents having the potential to be affected. All residents identified w/pressure ulcers have been examined and assessed for pain management by Vohra Wound Physician: 06/25-07/05/2012. Treatment Nurses received in-service training 1:1 by DON on assessing pain not only prior to dressing change to include after dressing change.	06/25/12 06/22/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator of Rocing	07/12/2012

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.

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F 309	Continued From page 1 A review of the treatment record for June 2012 indicated to clean the sacral ulcer with an antimicrobial, apply Aquacel AG (silver - a metallic element), Hydrocolloid, and change every three days until healed. A review of the sacral wound notes dated 6/17/12 noted at 3:30 pm indicated a measurement of 2.5 centimeters (cm) length x 1.5 cm width x 2 cm depth with undermining of 2 cm at 12 hour - 12 hour. On 6/20/12 at 8:20 am, Nurse #1 cleansed the sacral wound with an antimicrobial wound cleanser and used a cotton tip applicator to physically pack the Aquacel into the surrounding edges of the wound. Resident #170 guarded by pulling his body inward (pelvic region/lower torso) when Nurse #1 packed the Aquacel into the wound. Nurse #1 proceeded and completed the task without stopping, or inquiring from Resident #170 if there was any pain. In an interview on 6/20/12 at 8:30 am, Resident #170 indicated he experienced pain during the wound treatment. He stated his pain level on a scale of 1-10 was a "2/10", after the treatment was completed by Nurse #1. In an interview on 6/20/12 at 8:35 am, Nurse #1 stated she had not pre-medicated Resident #170 with any pain medication, but had assessed his pain level prior to the treatment which revealed no pain at 7:00 am. Nurse #1 added she was not sure how Resident #170 would tolerate pain meds due to his mental status, and that he jerked and had spastic movements all the time. Nurse #1 concluded there was no clinical documentation	F 309	page 2, continued from page 1. 3. Corrective Action Measures put into place to ensure deficient practice does not occur. Licensed staff received in-service training on pain assessment during each shift to include pre, during, and post dressing change by the DON on 06/23/12. Follow-up in-service reqarding F309 was conducted on 07/06/2012. Treatment Nurses #1 & #2 received 1:1 in-service training by the DON on 06/22/12 Vohra Wound Phyician notified of citation and F309 reviewed in facility on 06/25/12. 4. Corrective Action as Facility plans to monitor performance to ensure solutions are sustained. Treatment Nurses #1 & #2 will be monitored five (5) times per week for five (5) weeks for pre, during, and post pain assessment during dressing changes. This will be conducted once (1) weekly by Vohra Wound Physician and remaining four (4) times per week by DON, ADON, and Risk Manager. Upon completion of five (5) week monitoring, Vohra Wound Physician will monitor Treatment Nurses weekly until 2013 annual survey. This area of focus was added to facility QA on 06/27/2012 and will remain until 2013 annual survey.	07/06/12 07/06/12 07/06/12

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F 309	Continued From page 2 to support the spastic or jerking movements. A review of the nurse's notes dated 6/20/12 for 7:00 am revealed no documentation that supported a pain assessment was completed or documented by Nurse #1. During a follow up interview on 6/20/12 at 11:00 am (Rehab staff #1 present in room) Resident #170 indicated his pain level on a scale of 1-10 was a "3-4" when the ulcer treatment was being performed. He indicated at the present time his pain level was better with no pain indicated. In an interview on 6/20/12 at 1:00 pm, Resident #170 stated he did not recall his pain being assessed or pain medications offered to him before his ulcer treatment. He added he was use to the chronic pain; and that the nurses usually assessed his pain throughout the day. He concluded his pain was not any worse during the wound treatment; as it had been in previous care. In an interview on 6/20/12 at 1:10 pm, the Director of Nursing stated she expected the residents to be assessed for pain at least 30 minutes prior to the treatment procedure. She added that if guarding was observed during the treatment; the staff was expected to stop the treatment and reassess the resident's pain level prior to proceeding.	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date.	F 356	F365 - Posted Nurse Staffing Information SS = C Requirement: The facility will psot the following information on a daily basis: -Facility name -The current date. -The total numbers of hours worked by the following categories of licensed and unlicensed staff	

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F 356	Continued From page 3 o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interview and facility record review the facility failed to post the census on day one of survey and failed to post the total hours worked for licensed and unlicensed staff on 3 of 3 days during the recertification survey. The findings include: The first observation of the posted staffing	F 356	page 4, continued from page 3... nursing staff directly responsible for: -Registered Nurses -Licensed Practical Nurses or licensed Vocational Nurses (as defined under State Law) -Certified Nurse Aides Requirement: The facility will post the nurse staffing data specified above on a daily basis at the beginning of each shift. Requirement: The facility will, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. Requirement: The facility will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State Law, whichever is greater. 1. Corrective Action for those affected by deficient practice: There were no identified residents related to F356. The identified dates 06/18-20/12 were corrected and submitted to surveyor. On 06/20/12 Regional Nurse Consultant created, implemented, and submitt-ed "new form" to surveyor. Note: "new form" quantifies total hours/staff worked qshift & census. 2. Corrective Action for residents having the potential to be affected: There were no identified residents having the potential to be affected. On 06/20/12 the Regional Nurse Consultant in-serviced the DON/ADON on Posted Nurse Staffing Information; "new form" posted.	

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F 356	Continued From page 4 information was made on 6/18/12 at 10:30 AM on a bulletin board in the main lobby. The posted staffing information included the name of the facility, date (6/18/12) and number of licensed and unlicensed staff for first shift (7:00 AM until 3:00 PM). The posted staffing information did not include hours worked per shift or total hours worked for licensed and unlicensed staff. There was no census on the posted staffing information. The second observation of the posted staffing information was made on 6/18/12 at 5:02 PM. The posted staffing information dated 6/18/12 included the number of licensed and unlicensed staff for first shift and did not include any hours worked or the census. The third observation of the posted staffing information was made on 6/19/12 at 9:25 AM on a bulletin board in the main lobby. The posted staffing information included the name of the facility, date (6/19/12), census and number of licensed and unlicensed staff for first shift. The posted staffing information did not include hours worked per shift or total hours worked for licensed and unlicensed staff. The fourth observation of the posted staffing information was made on 6/19/12 at 5:15 PM. The posted staffing information dated 6/19/12 included the number of licensed and unlicensed staff for first shift and did not include any hours worked. The fifth observation of the posted staffing information was made on 6/20/12 at 8:35 AM on a bulletin board in the main lobby. The posted staffing information included the name of the	F 356	page 5, continued from page 4... 3.Corrective Active Measures put into place to ensure that deficient practice does not occur: On 6/20/12 Regional Nurse Consultant in-serviced the facility DON/ADON on Posted Nurse Staffing Information. On 6/22/12 the DON in-serviced all licensed staff on Posted Nurse Staffing Information w/ area of focus on census listing, total hours/staff working qshift with introduction of "new form" Posted Nurse Staffing Information. The DON in-serviced Third (3rd) shift nurses 1:1 training for completion of 3rd shift portion of form. The DON in-serviced First 1:1 /designated 1st shift Nurse Supervisors regarding completion of Posted Nurse Staffing Information on weekends and holidays when DON/ADON is not present in facility. The DON/ADON will be responsible for completion of 1st and 2nd shift posting of hours Monday-Friday. All licensed staff received follow-up in-service training from the DON on 07/06/12 regarding F356/ Posted Nurse Staffing Information. 4. Corrective Action as facility plans to monitor performance to ensure solutions are sustained: The facility Administrator and/or designee will monitor Posted Nurse Staffing Information for completion/accuracy 5 x qweek x5 weeks, then weekly x 5 weeks, then quarterly until 2013 annual survey. This solution added to facility's Quality Assurance on 6/27/12 and will remain until 2013 annual survey.	07/10/2012

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F 356	Continued From page 5 facility, date (6/20/12), census and number of licensed and unlicensed staff for first shift. The posted staffing information did not include hours worked per shift or total hours worked for licensed and unlicensed staff. The posted staffing information was reviewed from 6/6/12 through 6/20/12. The staffing information from 6/6/12 through 6/17/12 included the name of the facility, date, census and number of licensed and unlicensed staff for all shifts. The staffing information did not include hours worked per shift or total hours worked for licensed and unlicensed staff. The staffing information from 6/18/12 through 6/20/12 included the name of the facility, date, census (except for 6/18/12) and number of licensed and unlicensed staff for first shift only. No information had been entered for second (3:00 PM until 11:00 PM) or third (11:00 PM until 7:00 AM) shifts. The staffing information did not include hours worked per shift or total hours worked for licensed and unlicensed staff. On 6/20/12 at 10:30 AM the Director of Nursing (DON) indicated that either herself or the Assistant Director of Nursing were responsible for completing the posted staffing information for first and second shifts and a nurse on third shift was responsible for completing the third shift staffing information and census for the following day. The DON said she was not aware that the total hours worked for licensed and unlicensed staff had to be included on the posted staffing information and that staffing for second and third shift had been overlooked from 6/18/12 through 6/20/12.	F 356		

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, and is utilizing Delayed Egress Locking arrangements . The facility is equipped with an automatic sprinkler system.	K 000		
K 056 SS=E	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/4/2012 the facility has an area at the overhang for the post indicator valve for the automatic sprinkler system that is not protected by sprinkler coverage.	K 056	CFR#: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD SS=E Requirement: The facility will ensure an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance Of the Water-Based Fire Protection System. The facility will ensure there is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	8/24/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator of Nursing — (X6) DATE: 7/20/2012

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.

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K 056	Continued From page 1 CFR#: 42 CFR 483.70 (a)	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/4/2012 the Biohazard room on the A Hall has a sprinkler head that is blocked by a light fixture not allowing full coverage by the only sprinkler head in that space. CFR#: 42 CFR 483.70 (a)	K 062	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD SS=D Requirement: The facility will ensure automatic sprinkler systems are continuously maintained in a reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6, NFPA 25,9.7.5 1. Corrective Action for those affected by deficient practice. On 7/5/2012; the maintenance department installed new light fixtures in the A Hall Biohazard room in an arrangement that allows full coverage by the automatic sprinkler system. 2. Corrective action for residents having potential to be affected. Through random safety rounds, the maintenance department will ensure that nothing obstructs the coverage area intended for the automatic sprinkler system to properly fire protect all portions of the building. 3. Corrective Action Measure put into place to ensure deficient practice does not occur. The facility will ensure that any mechanical installation(s) conducted, by either maintenance staff or outside contractors, will not impede the coverage area of the automatic sprinkler system.	7/5/2012

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K062	Continued From page 1	K062	4. Corrective Action as Facility plans to monitor performance to ensure solutions are sustained. The maintenance department will, on a monthly basis, inspect and document that no sprinkler heads are blocked to prevent full coverage, by the automatic sprinkler system. Any evidence of deficient practice will be remedied immediately.	