PRINTED: 07/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION	 	(X3) DATE SURVEY COMPLETED		
<b>345378</b> B. WIN		B. WING _		C 06/21/201	8		
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPI	(5) LETION ATE
E 001 SS=F	CFR(s): 483.73  The [facility, except for comply with all application emergency prepared [facility] must establist comprehensive emergency must establist comprehensive emergency include, but not elements:  *[For hospitals at §48 comply with all application emergency prephospital must develog comprehensive emergency prephospital must develog comprehensive emergency prepared CAH at §485.6 with all applicable Feemergency prepared CAH must develop and comprehensive emergency program, utilizing and This REQUIREMENT by:  Based on record reversal facility failed to establication comprehensive emergency facility failed to addressed and the staff and during an emergency facility failed to addressed and the staff and during an emergency facility failed to addressed and the staff and during an emergency facility failed to addressed and the staff and	gency preparedness he requirements of this ency preparedness program be limited to, the following  82.15:] The hospital must cable Federal, State, and caredness requirements. The p and maintain a gency preparedness he requirements of this II-hazards approach.  825:] The CAH must comply deral, State, and local ness requirements. The nd maintain a gency preparedness all-hazards approach.  I is not met as evidenced  iew and staff interviews, the lish and maintain a gency preparedness. (EP) I the facility's comprehensive health, safety and security and resident population or disaster situation. The	E	This plan of written alleg Preparation correction diadmission of truth of the form of the conclustatement of the conclustatement of the conclusted the conclusion of the concl	of correction constitutes a gation of compliance. In and submission of this plate to the constitute and particular and a gation of constitute and a greement by the provide facts alleged or the correction usions set forth on the of deficiencies. The plan of a prepared and submitted	er of	18
	-Address the res delegation of authorit	ident population and y			use of requirements under ederal law.		
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	E

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/08/2018

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.

**Electronically Signed** 

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER: A. BUILDIN		IULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		7 20.23	<u> </u>		С	
	345378	B. WING _		o	6/21/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PRUITTHEALTH-ROCKINGHAM			804 SOUTH LONG DRIVE			
			ROCKINGHAM, NC 28379			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
officials -Assess Subsister residents -Develop a proced residents -Safe evacuation -Primary and alter communication -Plan to shelter in -System of sharing documentation, secure -Policy and proced volunteers -Emergency official -Method of sharing or representatives -Evidence of staff -Emergency powers system and fuel needs  The findings included:  Review of the facility Ethe facility with policies conducted. The manual	ocal, state and Federal EP nce needs for staff and lure for tracking staff and nate means of place g of medical ment and availability dure for emergency al Contact information g the EP plan with families training on the EP plan r and stand-by power  P plan manual provided by and procedures was al did not contain a written nsive EP program that met ts.  at 8:00 AM, the ne was aware of the e facility EP plan.	EO	1. The Facility Safety Committee (comprised of the facility Admin Maintenance Director, Director Services, Clinical Competency Coordinator, Housekeeping Suand Dietary Manager met on J for the annual review and mainthe facility Emergency Prepare Plan. During the meeting the foareas of the plan were updated discussed by the Committee M with documentation added to the binder: Resident Population and delegation of authority, Subsistenceds for the staff and residen procedure for tracking staff and safe evacuation, primary and a means of communication, shelplan, system of sharing medical documentation along with secular availability, policy and procedure of staff training on EF well as Emergency power and power system and fuel needs. Administrator met with the local Marshall & Fire Chief on 7/5/20 review the facility EP plan as we collaborate with local, state, and EP officials. Facility Administration this meeting to the facility	nistrator, of Health apervisor, uly 6, 2018 atenance of adness (EP) ollowing d and dembers he EP plan he d tence tts, d residents, alternate ter in place al arement bedure for d of sharing desentatives, of plan, as stand by The facility al Fire on the facility al Fire on the facility al federal tor added information		

Facility ID: 923337

AND BLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRI	UCTION	(X3) DATE SURVEY COMPLETED			
		345378	B. WING _				C / <b>21/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		EFIX (EACH CORRECTIVE ACTION SHOULD BE			
E 001	Continued From page	÷ 2	E	2. The accept deficie held of well a 7/6/20 covern Safety annual month effection needs received from from from the familie 7/5/20 yearly represent preparation opports to distribute the facility limproments.	e procedure for implementing the ptable Plan of correction for the ency cited is as follows: Meeting on 7/5/2018 with local EP officials as the annual review of the plan of 2018 ensure facility residents are red with an effective EP plan. Far by Committee met 7/6/2018 for all review of EP plan and will meet all the the review of EP plan and will meet hely thereafter to discuss EP plan inveness and make revisions as ed. Current Facility employees wed EP plan training on 7/6/2018 facility Administrator. Facility by EP plan trained at time hire erly regarding the facility EP plans inclusive to ensure facility EP plans inclusive to ensure facility EP plans inclusive to ensure facility EP plans inclusive and responsible parties on 2018. Facility will mail out information to current resident es and responsible parties on 2018. Facility will mail out information to resident families and sentatives regarding emergency aredness plan.  Cility Safety Committee will audit monthly during Safety Committee ings for accuracy and training runities. Findings of the audits we scussed by facility Administrator and Safety Committee (QAPI) meet and content of the summer of the properties of the audits we scussed by facility Administrator and Safety mittee Members will be responsible mittee Members will be respon	s s as on acility et and a. als de tate, or tion  EP e vill at e ting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345378	B. WING				21/2018
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E 001	Continued From page	e 3	E	001	for implementing this plan of correction 5. 7/19/2018		
F 584 SS=D	Safe/Clean/Comforta CFR(s): 483.10(i)(1)-	ble/Homelike Environment (7)	F	584	3. 1/19/2010		7/19/18
	but not limited to recesupports for daily living. The facility must prov §483.10(i)(1) A safe, homelike environment use his or her person possible.  (i) This includes ensureceive care and service care and service physical layout of the independence and do (ii) The facility shall ethe protection of the roor theft.  §483.10(i)(2) Housek services necessary to and comfortable interes §483.10(i)(3) Clean bein good condition;	ght to a safe, clean, elike environment, including siving treatment and ing safely.  iide-clean, comfortable, and it, allowing the resident to all belongings to the extent ring that the resident can rices safely and that the facility maximizes resident it is not pose a safety risk. Exercise reasonable care for resident's property from loss representations and maintenance of maintain a sanitary, orderly, ior;					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345378	B. WING		C 06/21/2018
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/21/2010
DDIUTTUE	ALTH BOOKINGHAM			804 SOUTH LONG DRIVE	
PRUITIHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG	,	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
F 584	Continued From page	e 4	F 584	4	
	, , , ,	table and safe temperature illy certified after October 1,			
		a temperature range of 71 to			
	§483.10(i)(7) For the sound levels.	maintenance of comfortable			
t f t	by:	Γ is not met as evidenced			
		on and interview the facility		The bathroom floors in rooms 140	
		ean bathroom as evidenced		144, 145, and 148 were deep cleane	d by
	, ,	stain at the base of the toilet		the housekeeping supervisor on	
		observed for environment		6/20/2018 with the caulking around the	ne
	(Room #s 140, 144,	145, and 148).		base of the commode in each room replaced by the facility Maintenance	
	On 6/18/18 at 9:30 a	m, 6/19/18 at 3:30 pm, and		Director on 6/20/2018. Rooms 140, 1	44,
	6/20/18 at 2:00 pm a	n observation was		145, and 148 had plumbing work don	e to
		ooms on C Hall. Rooms		commode to ensure proper function a	
		18 were observed to have a		caulking was not replaced which exp	osed
		at the base of the toilet and		the ring left by previous caulking.	
		be decaying. There was		Processes that lead to the deficiency	
	also an odor that res	embled mold.		were changes to facility monitoring of resident environment areas.	
	On 6/19/18 at 11:00 a	am the oriented resident in		TOSIGETIL GITVILOTITIETIL ALEAS.	
	room #144 stated that	at she thought the base of		2. The procedure for implementing th	e
	her toilet was dirty ar	nd had an odor. There was a		acceptable Plan of correction for the	
	brown ring around the	e base of the toilet and part		deficiency cited is as follows: Facility	
	of the tile was missin	g.		bathrooms in residents□ rooms were	
				inspected by the housekeeping supe	
	On 6/20/18 at 11:45			starting 6/21/2018 and ending 7/6/20	
		lall C housekeeper who		Resident bathroom floors on each of	
		e bathroom were cleaned,		facility units found by the Housekeep	_
	the brown ring was fr			Supervisor to need deep cleaning we	re
		and the tile was decaying		cleaned at the time of the inspection.	
		isture. The housekeeper		Resident bathroom floors in need of	
		ow if the brown was from		caulking on each of the facility units h	
	1	per had cleaned the floor with		work orders placed by the Housekee	_
	several different type			supervisor to the Maintenance Direct	
	appeared that the so	iling was stained into the tile	1	The Maintenance Director reviewed a	Iria

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F 609 SS=D	who stated that the c soiling and decay and supervisor had tried sproducts and had cut to improve the soil structure surrounding the toilet several years. The sthe base of the toilet remove the soiling strappearance.  On 6/20/18 at 2:00 producted with the Afacility does not current the decaying tile and resident's toilets. The aware that the caulking the soiling remained the toilet.  On 6/20/18 at 3:15 producted with mainticaulking was missing and there was brown several of the resider Maintenance was awaremoved when house bathroom floor.  Reporting of Alleged CFR(s): 483.12(c)(1)	am an interview was ousekeeping Supervisor aulking was removed due to d not replaced. The several types of cleaning away parts of the soiled tile aining. The floor had been soil stained for upervisor felt the tile around needed to be replaced to ain and improve the an interview was dministrator who stated the ently have a plan to correct soiling at the base of the endaministrator was not not had been removed and after cleaning at the base of the tolet staining from soiling in hit's bathrooms. The are that the soiling was not excepting cleaned the Violations	F 58	responded to the work orders placed in the system by the Housekeeping Supervisor. Facility administrative employees will note condition of bathrifloors on room round form with negative findings documented on the form and reported during AM meeting to the Maintenance Director and Housekeep Supervisor. Facility nursing, administrative, and housekeeping employees were educated on maintain a clean resident environment, with a foon bathrooms, on 7-6-18 by facility Administrator. Facility employees will receive training on maintaining a clear and safe resident environment upon hand annually.  3. Housekeeping Supervisor and Administrator will randomly audit ten resident bathrooms weekly for four we and then monthly. Results of audits were reported to facility QAPI Committee monthly by Housekeeping Supervisor Administrator.  4. Housekeeping Supervisor and Administrator will be responsible for implementing this plan of correction.  5.7/19/2018	oom ve  sing  ning ocus  n iire	

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F 609	involving abuse, new mistreatment, include source and misappor are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cause abuse and do not retthe administrator of officials (including to adult protective server for jurisdiction in lon accordance with Staprocedures.  §483.12(c)(4) Repositive stages accordance with Staprocedures.	re that all alleged violations glect, exploitation or ding injuries of unknown opriation of resident property, iately, but not later than 2 lation is made, if the events ation involve abuse or result in a contract of the allegation do not involve esult in serious bodily injury, to the facility and to other of the State Survey Agency and vices where state law provides agterm care facilities) in ate law through established and the results of all administrator or his or her intative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified we action must be taken. It is not met as evidenced are and record review, the at 24-hour and 5-day report to be sonnel Investigations Division asident (Resident #55 toward dent abuse. Resident #55 hit back of the head with no a Resident #3. This was for 1 and for resident to resident	F	1. Facility Administrator and Director of Clinical Services re-educated by facility RN Se Nurse regarding abuse reporemphasis on resident to residual tercations by 7-19-2018. Facemployees were re-educated prevention and reporting guid Director of Health Services on Resident #55 and Resident #55	were enior Clinical rting with dent acility d on abuse delines by the on 6-29-2018. #3 have had		

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			A. BOILDI		<del></del>	، ا	С	
		345378	B. WING				21/2018	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIUTTU	FALTIL DOCKINGUAM			80	04 SOUTH LONG DRIVE			
PRUITIH	EALTH-ROCKINGHAM			R	OCKINGHAM, NC 28379			
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F 609	dated last revised 4/2 state survey agency a protective services shaccordance with state procedures of any all hours after the allega upon which the allega abuse. If the events ubased do not involve serious injury, the allel later than 24 hours.  a. Resident #55 was diagnosis of unspecif #55's quarterly Minim 12/8/17 indicated he Mental Status (BIMS) moderate cognitive in coded for any behaviors. Resident #3 quarterly indicated a BIMS scocognitive impairment behaviors not directe. Review of a nursing r AM read Resident #5 wert allercation in the both residents were seriodents were seriodents were again.	ct, Exploitation, cappropriation of Property" 16/17 read as follows: The and state agency for adult nould be notified in a law through established egation of abuse within 2 tion is made if the events ation is based involves upon which the allegation is abuse and do not result in egation many be reported no admitted on 10/3/16 with a lied Schizophrenia. Resident thum Data Set (MDS) dated had a Brief Inventory of a score of 12 indicating inpairment and was not ors.  Idmitted 5/13/14 with a lied of seizures and dementia. If MDS dated 12/14/17 are of 2 indicating severe and he was coded for doward other.  Indicated 1/12/18 at 9:20 5 and Resident #3 had a lied hall. The note indicated separated at that time. It to the dining room where and and hit Resident #3 with back of the head. Both	F	609	2. The procedure for implementing the acceptable Plan of correction for the deficiency cited is as follows: Facility a of current residents  medical records facility Administrator started 7-6-2018 a ending 7-10-2018 failed to reveal evidence of unreported resident to resident altercations. Facility nursing, dietary, housekeeping, and administratemployees were re-educated on 6-29-2018 by Director of Health Services regarding abuse reporting guidelines. Facility employees not attending the 6-18 education will be re-educated during their next working shift by the DHS, Administrator, or Immediate Superviso Facility employees are educated on ab prevention and reporting upon hire and annually.  3. Facility Administrator and/or Department Heads will provide random scenarios to facility staff daily for fourted days, then weekly for two weeks, then monthly where staff must decide if the scenario constitutes a reportable incide or not. Results of scenarios and subsequent education will be reported the QAPI Committee meeting monthly ensure compliance.  4. Facility Administrator will be response for implementing this plan of correction 5.7/19/2018	udit by and tive -29- g r. buse d teen ent to to		

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F 609	as well as the physical Review of the facility 2018 to 6/21/18 did and documentation of an #55 and Resident #3 Review of an Interdia 1/12/18 indicated Resident psychological in-patient psychological in-patient psychological inpatient psychologica	both residents were notified cian.  vincidents list from January 1, not include any incident involving Resident 3.  sciplinary Team note dated esident #55's physical dent #3 was discussed. An	F 6	09			
		20/18 at 10:57 AM, the was no evidence that an					

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F 623 SS=C	on 1/12/18 involving Resident #3 was reported ADON stated the incide Administrator but she incident.  In an interview on 6/2 Administrator stated is met the criteria for reported and the	ompleted or that the incident Resident #55 toward orted to the state. The dent was reported to the felt it was not a reportable  0/18 at 1:05 PM, the she did not feel the incident porting to the state agency overe cognitively impaired.  Before Transfer/Discharge (6)(8)  before transfer.  fers or discharges a must-and the resident's me transfer or discharge and ove in writing and in a rethey understand. The popy of the notice to a Office of the State oudsman.  Is for the transfer or ent's medical record in graph (c)(2) of this section;  ce the items described in its section.  of the notice.  d in paragraphs (c)(4)(ii) and the notice of transfer or order this section must be taleast 30 days before the		609			7/19/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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					804 SOUTH LONG DRIVE		
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F 623	be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's heallow a more immedia under paragraph (c)(10) An immediate trained in the reside under paragraph (c)(10) A resident has not days.  §483.15(c)(5) Contennotice specified in paramust include the follodi) The reason for tradii) The location to what transferred or dischart (iv) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Ombox (vi) For nursing facility and developmental didisabilities, the mailin telephone number of	charge when- viduals in the facility would r paragraph (c)(1)(i)(C) of  viduals in the facility would r paragraph (c)(1)(i)(D) of  alth improves sufficiently to ate transfer or discharge, 1)(i)(B) of this section; asfer or discharge is ant's urgent medical needs, 1)(i)(A) of this section; or t resided in the facility for 30  Its of the notice. The written ragraph (c)(3) of this section wing: asfer or discharge; of transfer or discharge; of transfer or discharge; action the resident is ged; a resident's appeal rights, ddress (mailing and email), ar of the entity which ats; and information on how arm and assistance in and submitting the appeal as (mailing and email) and the Office of the State budsman; a residents with intellectual	F	623			

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F 623	C of the Developmer and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilidisorder or related diemail address and teagency responsible fadvocacy of individual established under the for Mentally III Individual established under the facility, and the residual established under the facility and the residual established under the established under the facility and the residual established under the facility and the residu	ilities established under Part natal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental sabilities, the mailing and elephone number of the for the protection and als with a mental disorder elephone natal elephone	F 623	1. On 6/20/2018 facility Administrator notified regional Ombudsman of facilit discharges occurring in the month of I Processes that lead to the deficiency were changes to the facility Social Word position and the need for education regarding resident discharge notificati	y May. cited orker	

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	1 00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 623	4/13/18 with diagnose cerebrovascular accir annual Minimum Data indicated Resident #3 impairment.  A review of the Reside indicated she had be and discharged from record revealed no do Ombudsman was not the reason for Reside hospital. Resident #3 facility on 4/13/18.  An interview was con Administrator on 6/19 asked who was responded who was responded by the stated she though Social Worker (SW), had a SW since Febrithe facility was still the The Administrator state to her staff and would information.  A follow up interview Administrator on 6/20 revealed the facility he Regional Ombudsmand discharges since son when their SW positic stated she phoned the discuss her preferred.	dent and dementia. The a Set (MDS) dated 3/29/18 as 7 had severe cognitive  dent #37's medical record en transferred to the hospital the facility on 4/10/18. The ocumentation that the tified in writing the date and ent #37's transfer to the as 7 was readmitted to the  ducted with the as 8/21/25 PM. She was consible for notifying the ent of any residents who had discharged from the facility. By the twould have been the but that the facility had not entary of 2018. She indicated for the swas going to speak as follow up with additional was conducted with the color at 4:30 PM. She had not been notifying the ent of transfers and the free follow up with additional was conducted with the color at 4:30 PM. She had not been notifying the ent of transfers and the free follows are regional Ombudsman to 1 method of communication to 1 stransfers and discharges.	F 623	2. Facility Administrator compiled residents discharged from the fact the past 90 days and submitted the regional Ombudsman via em. 7/5/2018. The list included resided discharge date, discharge location reason for discharge. On 6/20/20 facility Administrator spoke with Fombudsman and was instructed discharge list via email or facsimin Regional Ombudsman office each On 6/29/2018 facility Director of Services reviewed discharge notionand documentation with facility employees. Facility Administrator Social Worker will compile month discharge list and submit to region Ombudsman.  3. Facility Administrator will verify of discharged residents monthly a Regional Ombudsman via email documentation of verification. Verwill be presented to facility QAPI Committee monthly to ensure constituted to the constitute of the plan of correspondence of the plan of correspondence of the plan of correspondence of the past of th	cility for the list to ail on ent name, on, and on and or on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		' '	ATE SURVEY DMPLETED			
		345378	B. WING _			06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	facility send a month were transferred and	nly list of all residents who	F 6	23		
	facility on 8/14/14 at on 3/16/18 with diag and sepsis due to ut quarterly Minimum [	nd most recently readmitted in the individual included dementia rinary tract infection. The Data Set (MDS) dated 3/23/18 #332 had moderate cognitive				
	indicated she had be and discharged from record revealed no of Ombudsman was no the reason for Resid	dent #332 's medical record een transferred to the hospital in the facility on 3/11/18. The documentation that the otified in writing the date and lent #332 's transfer to the #332 was readmitted to the				
	asked who was resp Regional Ombudsm been transferred or She stated she thou Social Worker (SW) had a SW since Feb the facility was still t The Administrator st	nducted with the 9/18 at 2:35 PM. She was consible for notifying the an of any residents who had discharged from the facility. If you would have been the another that the facility had not be or work or work or work of 2018. She indicated the rying to fill the SW position. If you work or work o				
	Administrator on 6/2 revealed the facility Regional Ombudsm	was conducted with the 10/18 at 4:30 PM. She had not been notifying the an of transfers and metime in February of 2018				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			C <b>06/21/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 637 SS=D	stated she phoned the discuss her preferred regarding the facility. The Administrator rep Ombudsman requested facility send a monthly were transferred and/Comprehensive Asse CFR(s): 483.20(b)(2)(i) With determines, or should there has been a sign resident's physical or purpose of this section means a major declinates a major declinates for the resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplinates care plan, or both.) This REQUIREMENT by:  Based on staff intervice facility failed to complement of the reside requires in mental state unspecified Schizoph regime. This was for \$455\$) reviewed for unfindings included:	on became vacant. She se Regional Ombudsman to method of communication s transfers and discharges. orted the Regional sed that going forward, the y list of all residents who or discharged. ssment After Signifcant Chg iii)  nin 14 days after the facility have determined, that	F6		ave a sive a 18 by the nificant and occesses identified	7/17/18	
	cumulative diagnoses	nitted on 10/3/16 with sof anxiety, unspecified bral Vascular Accident.		understanding of behaviors as component constituting a Signif	a		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			06/2	; 21/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	1 00/2	1/2010
				804 SOUTH LONG DRIVE			
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 637	dated 7/3/17 read his depression. He was panxiety and depression. He was panxiety and depression. He was panxiety and depression. He was perfect that the dated 8/14/17 read hourspecified Schizoph disorder. He was new antipsychotic medical. Review of Resident #Set (MDS) dated 9/20 antipsychotic for 7 of for psychotic disorder. Review of the Care Adated 9/20/17 for behunchecked for new mas checked but Sch The accompanying now #55 had a diagnosis of multiple psychotropic. In an interview on 6/2 Nurse stated she did mental diagnosis with medications required the time the annual M 9/20/17.  In an interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st that a significant charman interview on 6/2 Director of Nursing st	255's Psychiatric Evaluation diagnoses were anxiety and prescribing medications for ion. 255's Psychiatric Evaluation was newly diagnosed with renia and other psychotic vly prescribed Risperdal (antion). 255's annual Minimum Data 20/17 was coded for taking an 7 days and he was coded (other than schizophrenia). 256 rea Assessment (CAA) avioral symptoms was redications, antipsychotics izophrenia was unchecked. 257 arrative note read Resident of Psychosis and taking medications. 257 AM, the MDS not realize that a new new antipsychotic a significant change MDS at 10S was completed on 121/18 at 12:10 PM, the ated it was her expectation nege MDS would have been effect Resident #55's new	F 6		plementing the rection for the ci ord audit was by Senior Nurse all survey. eiving antipsychatric diagnosis change were essment will be ally schedule. All lity and as well as ents within the diby the se Mix Coordinato wed In-service 6/25/18 related in Change to new diagnosis was provided for 6/28/18 by DHS are ceive education by the CCC. edure to ensure an of correction medication use in monthly until n	otic  as tor.  A to is on. r and on	
				4.The person responsit	ole for		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION		PLETED
		345378	B. WING _			1	C / <b>21/2018</b>
	ROVIDER OR SUPPLIER	1		80	TREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH LONG DRIVE OCKINGHAM, NC 28379	<u>,                                    </u>	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION S			(X5) COMPLETION DATE
F 637	Continued From pag	ne 16	F6	637	implementing the acceptable plan of correction: DHS/CRC/CCC and ADHS.  5.Completion date: 7/19/18		
F 641 SS=D	Accuracy of Assessr CFR(s): 483.20(g)	nents	F 6	641	3.00mpletion date. 7/13/10		7/17/18
	resident's status. This REQUIREMEN by: Based on record revision facility failed to compound (MDS) assessment a expectancy (Resident reviewed for hospice reviewed for hospice Resident #37 was material facility on 4/13/18 with cerebrovascular according and the state of the significant changes as a second facility on 4/17/18.  Hospice documentation Resident #37 was according to the significant changes as a second facility of the significant changes are second for the	st accurately reflect the  T is not met as evidenced  view and staff interview, the blete the Minimum Data Set accurately in the area of life at #37) for 1 of 1 residents  The findings included:  ost recently admitted to the th diagnoses that included ident.  dated 4/13/18 indicated a for Resident #37.  dated 4/17/18 indicated dmitted to hospice care on  tion dated 4/17/18 indicated dmitted to hospice on 4/17/18 nosis of late effects of			Accuracy of Assessments  1. The plan of the correction for the specific deficiency: Resident #37 MDs was corrected on 6/26/18 with J1400 b checked indicating Life Expectancy of months or less by the Case Mix Coordinator. Processes that lead to deficiency cited identified as change in MDS personnel and unclear understanding of checking Life Expectancy box without documentation physician in progress notes.  2. The procedure for implementing the acceptable plan of correction for the cit deficiency: Residents receiving hospical services were audited on 6/26/18. Findings from the audit revealed one other resident affected. Corrections we conducted on the MDS in section J100 6/26/18 and submitted to the state by the Case Mix Coordinator. New residents admitted to facility that meet the criteria for hospice services will receive a Significant Change assessment	n by ded de ere on he	

PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 641 Continued From page 17 during the last 14 days and while a resident at the facility. Section J, the Health Conditions section, had not indicated Resident #37 had a life  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 641 conducted by the CMC at the time the assessment is due. The DHS will visually observe that J1400 is checked. Licensed		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  PRUITTHEALTH-ROCKINGHAM  STREET ADDRESS, CITY, STATE, ZIP CODE  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)  F 641  Continued From page 17 during the last 14 days and while a resident at the facility. Section J, the Health Conditions section, had not indicated Resident #37 had a life  STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE OF CO			345378	B. WING _				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 641 Continued From page 17 during the last 14 days and while a resident at the facility. Section J, the Health Conditions section, had not indicated Resident #37 had a life  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 641 conducted by the CMC at the time the assessment is due. The DHS will visually observe that J1400 is checked. Licensed					804 SOUTH LONG DRIVE		,	
during the last 14 days and while a resident at the facility. Section J, the Health Conditions section, had not indicated Resident #37 had a life conducted by the CMC at the time the assessment is due. The DHS will visually observe that J1400 is checked. Licensed	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
An interview was conducted with the MDS Coordinator on 6/21/18 at 11:35 AM. She confirmed Resident #37 was admitted to hospice care on 4/17/18. A review of the significant change MDS assessment dated 4/26/18 that indicated Resident #37 was on hospice care, but did not have a life expectancy of six months or less (Question J1400) was reviewed with the MDS Coordinator. She revealed she was not aware that if a resident was on hospice that they also needed to be coded as having a life expectancy of less than 6 months.  An interview was conducted with the Director of Nursing on 6/21/18 at 12:10 PM. She indicated accurately.  received in-service training by the DHS on 6/25/18 in relation to J1400. Additional in-servicing was provided for Non-licensed staff on 6/28/18 by the DHS. New hires will received education on F641 during orientation by the CCC.  3.The monitoring procedure to ensure the effectiveness of the plan of correction constitute monitoring new referrals for hospice services daily x5, weekly x5, then monthly until next Annual Survey. Findings will be discussed monthly in QAPI.  4.The person responsible for implementing the acceptable plan of correction: DHS,CRC,CCC, and/or ADHS.	F 644	during the last 14 day facility. Section J, the had not indicated Resexpectancy of six moderated J1400).  An interview was cond Coordinator on 6/21/coonfirmed Resident #care on 4/17/18. A rechange MDS assessindicated Resident #did not have a life expless (Question J1400 MDS Coordinator. Sook aware that if a reside also needed to be consumed by the expectancy of less the sexpected the MD accurately.  Coordination of PASA CFR(s): 483.20(e)(1)  §483.20(e) Coordinator A facility must coordination of PASA CFR(s): 483.20(e)(1)  §483.20(e) Coordinator A facility must coordination of PASA Resident PASARR levaluation of the PASARR levaluation of the PASARR evaluation of the PASARR evaluation of the pasage of the pasage of the PASARR evaluation of the pasage	ys and while a resident at the e Health Conditions section, sident #37 had a life onths or less (Question and ucted with the MDS 18 at 11:35 AM. She #37 was admitted to hospice eview of the significant ment dated 4/26/18 that 37 was on hospice care, but pectancy of six months or and of the revealed she was not ent was on hospice that they are an 6 months.  Inducted with the Director of the 12:10 PM. She indicated as having a life an 6 months.  Inducted with the Director of the 12:10 PM. She indicated and ARR and Assessments (2)  Ition.  In the assessments with the ming and resident review under Medicaid in subpart C aximum extent practicable to the ting and effort. Coordination to trating the recommendations are life the report into a resident's		ca a co N re 66 ir N N d 33 e cc h n w 44 ir c	assessment is due. The DHS will visuabserve that J1400 is checked. Licens Nurses and Case Mix Coordinator ecceived in-service training by the DHS (25/18 in relation to J1400. Additional n-servicing was provided for Non-licensed staff on 6/28/18 by the ENEW hires will received education on Eduring orientation by the CCC.  B. The monitoring procedure to ensure effectiveness of the plan of correction constitute monitoring new referrals for mospice services daily x5, weekly x5, the monthly until next Annual Survey. Find will be discussed monthly in QAPI.  The person responsible for emplementing the acceptable plan of correction: DHS,CRC,CCC, and/or AECC.	ally sed S on I DHS. =641 the then dings	7/17/18

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	PLE CONSTRUCTION  G		COMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379		00/21/2010
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F 644	all residents with ne serious mental disorrelated condition for a significant change. This REQUIREMEN by: Based on staff interreview, the facility fanewly evident diagnillnesses for Pre-Ad Annual Resident Rescreen for 2 of 2 res (Residents #48 and The findings include 1. Resident #48 was 5/16/11 with a PASA 11/01/10 which indictevel II. Resident # related diagnoses in facility.  The quarterly Minimassessment dated 1 #48 's cognition was other behavioral syradministered antips antidepressant mediactive diagnoses incomplete.	rring all level II residents and ewly evident or possible rder, intellectual disability, or a level II resident review upon in status assessment.  IT is not met as evidenced reviews and medical record ailed to refer residents with loses of serious mental mission Screening and eview (PASARR) Level II sidents reviewed for PASARR #55).	F 6		rector. On ws on #48 DS 7/5/18 for Process dentified and ss for  g the the dical SNC on lesidents JRR Level SARR 22/18, tive residents.	
	dated 12/12/17 inclupsychosis, mood dis	are conference meeting note uded the diagnoses of sorder, major depressive by disorder for Resident #48.		CMC per MDS schedule. New act to facility as well as present residure identified for new diagnosis vereferred to PASARR representation PASARR Screening by the Social	dents that will be ive for	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		345378	B. WING _			06	6/21/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
DDIIITTUE	EALTH-ROCKINGHAM			80	04 SOUTH LONG DRIVE		
PROTTINE	EALTH-ROCKINGHAW			R	OCKINGHAM, NC 28379		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 644			F 6	644			
	She was noted with frinappropriate yelling.	requent socially			and/or Admissions Director. Licensed Nurses and CRC received In-service		
	The quarterly Minimu	m Data Set (MDS)			training by the DHS on 6/25/18 in relat to identified components that require	ion	
	assessment dated 2/8	8/18 indicated Resident #48			referral for PASARR Level Screening.		
		erely impaired. She had			Non-Licensed Staff received additiona		
		other behavioral symptoms			in-servicing on 6/28/18 by the DHS. No	€W	
	on 1 to 3 days. She				hires will receive education on F644		
		tion, antianxiety medication,			during orientation by the CCC.		
	•	nedication on 7 of 7 days. included psychotic disorder,			3 The manitoring precedure to ensure		
		ty disorder, and depression.			3. The monitoring procedure to ensure effectiveness of the plan of correction		
	mood disorder, drixie	ty disorder, drid depression.			constitutes monitoring orders related to	)	
	A multidisciplinary car	re conference meeting note			new mental health diagnosis and	•	
	dated 2/22/18 include				psychotropic medication orders dailyx	5,	
	psychosis, mood disc	order, major depressive			weeklyx5, then monthly until next Annu	ıal	
	disorder, and anxiety	disorder for Resident #48.			Survey. Findings will be discussed		
	She was noted to be				monthly in QAPI. The Admissions Core	<b>.</b> t	
	medications and was				and DHS will monitor and take the		
		Resident #48 was indicated			information to QAPI.		
		nstantly and deny any			4.71		
	problem when asked.				4.The person responsible for		
	A novehiatria avaluati	on note dated 4/25/19			implementing the acceptable plan of correction: Social Worker/Admissions		
	indicated Resident #4	on note dated 4/25/18			Director/DHS/CMC.		
	experience anxiety ar	<u> </u>			Director/Dr 13/Civic.		
		s in mood) per staff report.			5.Completion Date: 7/17/18		
	A gradual dose recom				o.completion Bate. 1711710		
	•	ned due to the likelihood it					
		at #48 to decompensate.					
	Resident #48 was no	-					
	medications that inclu						
	medication, antianxie						
	antidepressant medic	cation, and a mood stabilizer.					
		liagnoses of schizophrenia					
		sychotic disorder, anxiety,					
	and mood disorder.						
	The annual Minimum	Data Set (MDS)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345378	B. WING			C <b>06/21/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	<u> </u>	00/21/2010
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F 644	to have a serious medisability or a related cognition was severe behavioral symptoms interfered with social privacy of others, an environment. She wantipsychotic medica and antidepressant relative diagnoses mood disorder, anxied.  Resident #48 's plar included the problem anxiety, psychosis, at taking psychotropic recare also included the #48 having outbursts singing loudly.  A psychiatric evaluate indicated Resident #48 was not medications that included the experience anxiety and medication, antianxied antidepressant medication, antianxied antidepressant medication was noted with spectrum and other pand mood disorder.  Review of the June 2 summary and Medicindicated Resident #4 antipsychotic medications medication medication medicated resident #4 antipsychotic medication medication medicated resident #4 antipsychotic medication medication medication medication medication medicated resident #4 antipsychotic medication med	18/18 Section A 1500 48 was not currently ate Level II PASARR process ental and/or intellectual condition. Resident #48 's ely impaired. She had other is on 4-6 days which activities, intruded on the discrupted the care as administered ention, antianxiety medication, medication on 7 of 7 days. Is included psychotic disorder, ety disorder, and depression.  In of care, updated on 5/22/18, ention of the diagnoses of entid depression in addition to medications. This plan of the problem/need of Resident is of yelling, squealing, and  ion note dated 6/7/18 48 was continuing to end yelling out per staff report. Entire of the diagnoses of the diagnoses of the problem/need of Resident the of yelling out per staff report. The diagnose of the diagnose of the diagnose of the diagnose of the problem/need of Resident the of yelling out per staff report. The diagnose of the diagno	F 64	44		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C <b>6/21/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		0/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 644	An interview was of Coordinator (AC) of stated she was preceded from the facility. January of 2018. Sposition was currently when a resident was mental illness their evaluated for a Levist medical record that to the facility with a mental health diag. AC. The medical right #48 presently was medication, antians antidepressant meas well as being serelated to the diagricular spectrum and othe and mood disorder She revealed she hat the changes in Resishe was the SW. Simade aware she was Level II PASARR referral for a Level been made for Residen at 1945 to complete a referevaluation for Residen An interview was considered and not been at 1945 to complete a referevaluation for Residen and not been at 1945 to 2018.	conducted with the Admissions on 6/20/18 at 9:22 AM. She eviously the Social Worker but had switched to the AC in She indicated the facility 's SW on the switched to the AC in She indicated the facility 's SW on the switched to the AC stated as newly diagnosed with a resident needed to be well II PASARR. Resident #48 ' wat indicated she was admitted a Level I PASARR and no moses was reviewed with the receiving antipsychotic exiety medication, dication, and a mood stabilizer rene by psychiatry services moses of schizophrenia repsychotic disorder, anxiety, was reviewed with the AC and not been made aware of sident #48 's diagnoses when She indicated if she had been would have made a referral for a evaluation. She confirmed no II PASARR evaluation had sident #48.	F	544			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			C <b>06/21/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		TION
F 644	the regulation to be for 2. Resident #55 was cumulative diagnoses convulsions and Ceres. Review of Resident # dated 8/14/17 read hourspecified Schizoph disorder. He was new antipsychotic medica.  An interview was con Coordinator (AC) on stated she was previous (SW) at the facility, bus January of 2018. She position was currently when a resident was mental illness the resevaluated for a Level medical record that in the facility with a Level health diagnoses was medical record indical presently was receiving antianxiety medication well as being seen by to the diagnoses of unand psychosis. This was the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW. She made aware she would a Level II PASARR evental in the changes in Resid she was the SW.	admitted on 10/3/16 with a of anxiety, unspecified abral Vascular Accident.  55's Psychiatric Evaluation a was newly diagnosed with renia and other psychotic and othe	F	344			
	been made for Resid	ent #55. was conducted with the AC					

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345378	B. WING			1	C
NAME OF PR	OVIDER OR SUPPLIER	343376	] B. Wiito		STREET ADDRESS, CITY, STATE, ZIP CODE	06/	21/2018
	ALTH-ROCKINGHAM			8	04 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=D	to complete a referral evaluation for Resider evaluation for Resider An interview was considered. An interview was considered and not been away in PASARR evaluation evident diagnosis of a identified. She indicate the regulation to be for Develop/Implement of CFR(s): 483.21(b)(1)  §483.21(b) Comprehe §483.21(b)(1) The fact implement a comprehe care plan for each resident rights set for §483.10(c)(3), that indobjectives and timeframedical, nursing, and needs that are identificated assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.24, §483. provided due to the required systems of the residential provider systems of the residential providered systems of the residential physical in the residential physical phy	M. She stated she was going for a Level II PASARR in #55 today (6/20/18).  ducted with the /18 at 1:20 PM. She stated are that a referral for a Level in was required when a newly in serious mental illness was sted her expectation was for followed.  comprehensive Care Plans stillity must develop and densive person-centered stident, consistent with the stin at §483.10(c)(2) and colludes measurable arms to meet a resident's mental and psychosocial ded in the comprehensive care plan must person to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 1.10(c)(6).  ervices or specialized the nursing facility will		656			7/17/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE COMP	
		345378	B. WING _			06/3	21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	DDE		
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F 656	rationale in the resid (iv)In consultation wiresident's represental (A) The resident's godesired outcomes.  (B) The resident's profuture discharge. Fawhether the resident community was assolical contact agencie entities, for this purp (C) Discharge plans plan, as appropriate requirements set for section.  This REQUIREMEN by:  Based on record resinterview the facility comprehensive care psychotropic medical contracture manage 23 residents reviewed included:  1. The resident was Resident #27's quar 4/10/18 revealed the hearing, clear speed understands. The recognition. Activities extensive assistance transfers and one strassistance except medical contracture with the second contracture included:	aRR, it must indicate its ent's medical record. ith the resident and the ative(s)-bals for admission and reference and potential for cilities must document it's desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care, in accordance with the th in paragraph (c) of this  T is not met as evidenced view, observation and failed to develop a plan in the areas of thion (Resident #37) and ment (Resident #37) and ment (Resident #27) for 2 of a for care plan. The findings admitted on 5/17/17.  Iterly minimum data set dated a resident had an intact of daily living required a for two staff members for all aff members for all other leals were set up. The active hiplegia and contracture of	F 6	1.The plan of correction for deficiency: Resident #27 wa by Physical Therapy and ad caseload on 6/25/18 for Ortl Management and Training. obtained on 6/25/18 for adjuextension splints of Bilatera Extremities to accommodate of bilateral knees. Application Nursing directives on monite also obtained. The Care Pla POS/MAR was updated on DHS and Primary Nurse. Rereceived orders to discontin and Begin Scheduled Ativar agitation on 6/20/18 by the I during Annual Survey. The #27 was also updated on 6/CMC to reflect the use of At Anti-anxiety medication. Prolead to the deficiency cited a	as evaluated ded to hotic Orders were usted knee I Lower e contracturon time and oring were an and 6/25/18 by the sident #37 true prn Ativan for terminal Hospice Nui Care Plan of 1/26/18 by the tivan as an ocesses that	e res the an al rse of e	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′				OATE SURVEY OMPLETED	
			, 50.25.	_		,	С	
		345378	B. WING			06/	21/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 656	Continued From page	e 25	F	656				
	· -	9/26/17 revealed physical			change in MDS and Therapy personne	l as		
		ek for 6 weeks for treatment			well as discontinuation of residents from			
	of positioning, orthotic				Restorative program without directives			
	management.				floor staff for continuation of contractur			
					management.			
		nt's care plan dated 4/23/18						
		no goals or approaches for			2. The procedure for implementing the			
		lateral knees and splint			acceptable Plan of correction for the			
	placement.				deficiency cited: Audit conducted by D on 6/26/18, for residents with noted	10		
	Monthly physician ord	ders dated 5/30/18 revealed			contractures and 6/28/18 for residents			
		nsult for bilateral knee			receiving prn psychotropic medications	<b>.</b>		
	splints versus dynam				Two residents were noted as affected			
		·			related to contractures and 6 residents			
	On 6/18/19 at 3:30 PI				were affected in relation to prn use of			
		ne and the resident stated to			psychotropic medications. Identified			
		that the staff did not know			contractures received evaluation from			
		nt and that he had been			Therapy Services and orders were			
		he past. The resident had nees. The knee splint			obtained for contracture management. Identified residents receiving prn			
		ce but was sitting on top of			psychotropic medication received			
	the cabinet.	oo bat was sitting on top of			changes in orders in relation to			
					timeframes for the use of these			
	On 6/18/18 at 3:40 PI	M, an interview was			medications. Care Plans and POS/MA	Rs		
	conducted with Resid	ent #27 who stated he had			received updates related to the identification	ed		
		I was wearing the knee			changes on 6/27/18 by DHS and CRC	·		
		it helped him. The resident			New admissions to facility will be			
		know why "they don't put			assessed by the DHS/ADHS and/or			
	the pillow between m	y legs arrymore.			primary nurse for contracture management and use of psychotropic			
	On 6/21/18 at 2:00 PI	M, the Director of Nursing			medications with duration for any order	red		
		stated she expected the			prn usage. The DHS will ensure	- =-		
		e plan according to the			communication to Therapy Outcomes			
	resident s needs.				Coordinator via Daily Clinical Meetings	•		
		admitted to the facility on			Licensed Nurses received in-service			
		ntly readmitted on 4/13/18			training by the DHS on 6/25/18 in relat	.on		
	with multiple diagnose	es that included dementia.			to monitoring and documentation of			
	The significant of	o Minimum Data Cat (MDC)			contracture Management, use of prn			
	i i ne significant chang	e Minimum Data Set (MDS)	1		psychotropic medications with the		1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		345378	B. WING				C (24/2048
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PRUITTHE	ALTH-ROCKINGHAM						
				K	OCKINGHAM, NC 28379		
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F 656	Continued From page	e 26	F 6	656			
F 656	assessment dated 4/2 #37 had severely impreceiving hospice ser received antianxiety r MDS look back period A physician's order da (antianxiety medicatid 4 hours as needed (FResident #37.  A review of the May 2 Medication Administratindicated Resident #37 multiple times each m Resident #37's compreviewed on 6/21/18. updated on 5/10/18 aproblems/needs, goat the use of psychotrop (Ativan).  An interview was con Coordinator on 6/21/2 dated 5/3/18 for PRN reviewed with the MD 2018 and June 2018 indicated she receive each month was reviewed coordinator. The cor Resident #37 that income the use of psychotrop was reviewed with the material reviewed with the month was review	26/18 indicated Resident vaired cognition. She was vices and she had not medication during the 7-day d.  2018 and June 2018 attion Records (MARs) are ceived PRN Ativan month.  2018 and June 2018 attion Records (MARs) are received PRN ativan month.  2018 and June 2018 attion Records (MARs) are received PRN ativan month.  2018 and June 2018 attion Records (MARs) are received PRN ativan month.  2018 and June 2018 attion Records (MARs) are received PRN ativan month.  2018 and June 2018 attion Records (MARs) are received PRN ativan month.  2018 and June 2018 attion The care was month.  2018 and June 2018 attion The care plan was noted to mode included no less or interventions related to mode antianxiety medication  2018 attion Resident #37 was as a Coordinator. The May MARs for Resident #37 that dependent	F6	356	directive of no longer than 14 days duration, and Care Plan documentation/revision. Additional train was provided on 6/28/18 by the DHS. New hires will receive education on F6 during orientation by the CCC.  3. The monitoring procedure to ensure effectiveness of the plan of correction constitutes monitoring orders related to psychotropic medications and identified contractures dailyx5, weekly x5, then monthly until next Annual Survey. The DHS/ADHS and CCC will be responsible for monitoring orders and identified contractures. The designated Charge Nurse will be responsible for assessing new residents for weekend admissions regards to medications and contracture. The information will be kept in the acut charting book. Findings will be discuss monthly in QAPI by the DHS.  4. The person responsible for implementing the acceptable plan of correction: DHS/ADHS/TOC, and/or Primary Nurse.  5. Completion date: 7/17/18	the d lie	
	psychotropic antianxi	o include the use of the ety medication.  ducted with the Director of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345378	B. WING			06/	21/2018
	ROVIDER OR SUPPLIER			80	TREET ADDRESS, CITY, STATE, ZIP CODE 04 SOUTH LONG DRIVE COCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	she expected the plar centered and compre indicated that if a resi	: 12:10 PM. She indicated his of care to be person hensive. She additionally dent was receiving ions she expected this to be of care.		656			7/17/18
F 65/ SS=D	S483.21(b) Comprehe §483.21(b)(2) A complete §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not limically (A) The attending phy (B) A registered nurse resident.  (C) A nurse aide with resident.  (D) A member of food (E) To the extent practive the resident and their An explanation must medical record if the pand their resident repnot practicable for the resident's care plan.  (F) Other appropriate disciplines as determined as requested by the (iii) Reviewed and revite am after each asses comprehensive and cassessments.	ensive Care Plans brehensive care plan must  I days after completion of essessment. Bredisciplinary team, that ited to resician.  I with responsibility for the  I and nutrition services staff. Breticable, the participation of esident's representative(s). Bre included in a resident's participation of the resentative is determined to development of the  staff or professionals in lined by the resident's needs the resident.  I seed by the interdisciplinary the sement, including both the		007			//1//18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		345378	B. WING		0	C 6/ <b>21/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	1 11 1		STREET ADDRESS, CITY, STATE, ZIP COD	•	0/2 1/20 10
				804 SOUTH LONG DRIVE		
PRUITTHE	ALTH-ROCKINGHAM			ROCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 28	F 6	57		
F 657	Based on record revinterview the facility facomprehensive care alarms for 2 of 5 resignation (Residents #23 and 2).  1. The resident was a Resident #27's quarted 4/10/18 revealed the hearing, clear speech understands. The rescognition. Activities of extensive assistance transfers and one state assistance except mediagnoses were hemit the bilateral knees and A review of Resident there was a fall goal of alarm and to check the function during round documented.  A review of the physic revealed it was discosioned.  On 6/18/18 at 2:45 Physical company for the physical control of t	iew, observation, and ailed to revise the plan in the area of bed dents reviewed for accidents (27). the findings included: admitted on 5/17/17.  erly minimum data set dated resident had adequate and an intact of daily living required of two staff members for all off members for all other eals were set up. The active iplegia and contracture of aid right hand.  #27's care plan revealed with an approach for a "bed ne bed alarm placement and	F 6	1.The plan of correction for the deficiency: Resident #27 and received clarification orders to alarms and Y connectors due on 6/20/18 during Annual Surn DHS and Primary Nurse. Care revised on 6/22/18 by DHS and Nurse to reflect the nonuse of Processes that lead to cited didentified as changes in MDS and Licensed Nurses lack of Pregarding care plan updates to 2.The procedure for implemer acceptable plan of correction deficiency: Audit conducted by Primary Nurse on 6/27/18, for care planned at risk for falls. A findings revealed 11 residents identified as affected. Interver audited and removal of nonus were removed from the Care 6/27/18. Physicians Orders who by DHS/CCC and Primary Nuclarification orders were obtain removal from POS/MARs. Ne admissions to facility will be a fall risks with interventions refalarms by DHS and Primary Nuclaries by DHS and Primary Nuclaries Licensed Nurses receivin-service training by the DHS	#23 of discontinue to nonuse vey by the e Plans were nd Primary falarms. reficiency personnel knowledge imely.  Inting the for the cited by DHS and residents Audit sewere intions were re devices Plans on here audited hed for w ssessed for fraining from hurse. In new admit brimary wed	
	who stated that her e comprehensive care there were resident c	ssistant Director of Nursing xpectation was for the plan to be updated when		in-service training by the DHS in relation to Care Plan revision accurate use of interventions. education was provided on carevisions for interventions not use. Additional training was p 6/28/18 by the DHS. New Hire	ons to reflect Focus are plan longer in rovided on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C <b>6/21/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	•	0/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 657	diagnoses included a osteoarthritis.  A quarterly Minimum 4/5/18 indicated Res long-term memory in impaired in decision-behaviors were note period. Impairment of to bilateral lower extrutilized during the as A care plan last revie Resident #23 was at mobility, poor safety cognitive status, fidg posture and contract extremities. Approacheck alarm each shiplacement. "Y" control on 6/18/18 at 2:30 F conducted with Nurs #23 required total castaff used bolster customention the use of a Resident #23.  On 6/18/18 at 2:50 F Resident #23 was control of the state of t	Data Set (MDS) dated ident #23 had short-term and inpairment and was severely making skills. No mood or diduring the assessment of range of motion was noted remities. No restraints were issessment period.  Ewed on 4/8/18 indicated risk for falls related to poor awareness, impaired ety movements, abnormal tures to bilateral lower ches included, in part, to iff for function and frector to alarm.  EM, an interview was e #2. She stated Resident re by staff. Nurse #2 said shions in both sides of the ining in the chair. She did not my type of alarms used for enducted. She was lying in	F 65	,	o ensure the orrection ntions and ailyx5, annual assed		
	her Geri-chair. No a or attached to the be On 6/19/18 at 2:45 F conducted with the E they stopped using the	larms were seen on the chair d.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
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PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
conducted with the M she was responsible reviewed the care plastated it must have be Services Provided Me CFR(s): 483.21(b)(3) Comprosite Services provided as outlined by the commust- (i) Meet professional: This REQUIREMENT by: Based on record reviewed Psychiatric Nurse Prafacility failed to admin medications as ordere #10) for 1 of 2 resider and emotional status.  Resident #10 was inition 4/14/14 and most 2/1/16 with multiple d major depressive discannual Minimum Data dated 3/16/18 indicate was intact. She receimedication during the A physician 's order for 5/22/18 indicated the (antipsychotic medications)	AM, an interview was DS Coordinator. She stated for the implementation, g of the care plans. She in for Resident #23 and een an oversight. Set Professional Standards (i) ehensive Care Plans d or arranged by the facility, imprehensive care plan, standards of quality. It is not met as evidenced ew, staff interview, and actitioner interview, the dister antipsychotic ed by a physician (Resident ints reviewed for behavioral The findings included: itially admitted to the facility recently readmitted on inagnoses that included order and psychosis. The a Set (MDS) assessment ed Resident #10 's cognition oved no antipsychotic	F 6		cific eview mary lers 25/18. ency sight of the	/17/18

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		l` ´coı		TE SURVEY MPLETED	
			A. BOILDI	NG _		، ا	c	
		345378	B. WING				21/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DDIJITTU	ALTH BOCKINGHAM			80	04 SOUTH LONG DRIVE			
PRUITINE	EALTH-ROCKINGHAM			R	OCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	5/22/18 indicated a g Resident #10 's Sero medication) to 75 mg Seroquel 50 mg twice Seroquel 50 mg once discontinue Seroquel A review of Resident Administration Record 0.25 mg twice daily from twice daily were a MAR on 5/22/18, but administered in May. indicated Resident #1 of Seroquel was added on 5/22/18, was initial administered as ordered A review of Resident indicated Risperdal 0 initiated on 6/1/18. For received Risperdal 0 initiated on 6/1/18. For received Risperdal 0 in the serior of the control of the	An additional order dated radual dose reduction of oquel (antipsychotic twice daily for 3 days, then e daily for 3 days, then e daily for 3 days, and then e daily for 6 days and Risperdal or 7 days and 8 desident #10 's mark additionally 10 's gradual dose reduction ed to Resident #10 's MAR end to 10 to 10 days and was red until it was discontinued.  #10 's June 2018 MAR essident #10 had not 125 mg twice daily was 125 mg twice daily for 6 days and additional educted with the Director of 120/18 at 11:55 AM. She en out of the facility for the earn out of the facility fo	F	658	POS/MAR with the medical record, Medication Administration Record, and any new orders from the previous day. Clarifications were obtained and added July POS/MARs. New admissions to facility will receive orders written in medical record and POS/MAR by the DHS/ADHS and/or primary Nurse. MAR and reviewing of orders will be conduct by the DHS/ADHS/CCC and/or primary nurse. Licensed Nurses received in-service training by the DHS on 6/25/with additional training on 6/28/18 by th DHS and CCC regarding the 3 step process of checking the POS/MAR with the Medical Record. Return demonstration of the 3 step process was performed by the Licensed Nurses to the DHS and CCC. This process will be utilized for orders obtained and monthly changeover and Care Plan revisions. Each hall will be assigned to DHS, ADR and CCC for monitoring. New hires will receive education on F658 during orientation by the CCC.  3. The monitoring procedure to ensure effectiveness of the plan of correction constitutes monitoring orders, care plan revisions, and POS/MAR revisions focused on psychotropic medications dailyx5, weeklyx5, then monthly until not Annual Survey by the DHS. Finding will discussed in Monthly QAPI by the DHS.  4. The person responsible for	I to Rs led I 18 le le le Rs le le Rs le R		
	s gradual dose reduc	's orders for Resident #10 ' tion of Seroquel and the were indicated to occur			implementing the acceptable plan of correction: DHS, ADHS, and CCC.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345378	B. WING			21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	1 00/	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	Risperdal had not been She revealed Resider Risperdal 0.25 mg twi 0.5 mg twice daily. She process was for review ensure they matched administered as order several different nurse orders at the end of extere was not one per review. She reported the DON were responstask. The ADON revet these errors previous!  A phone interview was Psychiatric Nurse Pra at 10:40 AM. The 5/2 Resident #10's gradic Seroquel and the initial reviewed with the PNI made these two order and she intended for I simultaneously. She had several medications ordered, but she belied negative effects from A follow up interview was DON on 6/21/18 at 12	confirmed Resident #10 's en administered as ordered. In #10 had not received ce daily prior to receiving he was asked what the wing orders and MARs to and that medications were red. The ADON stated that hes reviewed MARs and each month. She indicated from responsible for the that ultimately herself and his he was unaware of y.  Is conducted with the ctitioner (PNP) on 6/21/18 2/18 physician 's orders for all dose reduction of ation of Risperdal were P. She stated she had so (Seroquel and Risperdal) conton to occur reported that Resident #10 on adjustments in an effort ive dosage. She stated she had no ever the stated she had no ever the stated she had so to be administered as eved Resident #10 had no	F 65	5.Completion date: 7/17/18.		
F 688 SS=D	0==() (0==()()	rease in ROM/Mobility (3)	F 68	8		7/17/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
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PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
resident who entrange of motion range of motion condition demonor of motion is unaw §483.25(c)(2) A motion receives services to increprevent further describes appropriately assistance to mathe maximum proceduction in mobion This REQUIREM by:  Based on recordinterview the factor bilateral contractoriem the residents review Physician order therapy 5x week positioning, orthor Review of the rerevealed there we contractures of the placement.  Monthly physicial prosthetic/orthor splints versus dy	lity.  le facility must ensure that a lers the facility without limited does not experience reduction in unless the resident's clinical strates that a reduction in range voidable; and  resident with limited range of appropriate treatment and lase range of motion and/or to ecrease in range of motion.  resident with limited mobility riate services, equipment, and lintain or improve mobility with lacticable independence unless a ility is demonstrably unavoidable.  IENT is not met as evidenced  of review, observation and lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered for 1 of lity failed to place a knee splint lacted knees as ordered physical for 6 weeks for the treatment lotic evaluation and management.  Is ident's care plan dated 4/23/18 lere no goals or approaches for lity failed to place a knee splint lateral knees and splint  orders dated 5/30/18 revealed c consult for bilateral knee	F 68	1.The plan of correction for the spect deficiency: Resident #27 was evaluate by Physical Therapy and added to caseload on 6/25/18 for Orthotic Management and Training. Orders we obtained on 6/25/18 for adjusted kneextension splints of Bilateral Lower Extremities to accommodate contract of bilateral knees. Application time and Nursing directives on monitoring were also obtained. The care plan and POS/MAR were revised by the DHS Primary Nurse on 6/25/18. Process that lead to the deficiency cited attribute to change in MDS and Therapy personal well as discontinuation of resident from Restorative program without directives to floor staff for continuation contracture management.	ted  ere e  tures nd e  and es  uted onnel ss

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		DATE SURVEY COMPLETED
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F 688	the Treatment Nurse how to place the splin wearing the splint in the bilateral contracted known device was not in placabinet.  On 6/18/18 at 3:40 proconducted with Reside contracted knees and splint which helped held he did not know why between my legs any On 6/19/18 at 4:00 proconducted with Physistated Resident #27 started 10/2017 and his bilateral knees by was educated on how knee splint used for 2 the day on a continued.	the and the resident stated to that the staff did not know at and that he had been the past. The resident had nees. The knee splint ce but was on top of the man interview was dent #27 who stated he had d was wearing the knee im. The resident stated that "they don't put the pillow more."	F 6		menting the ion for the iducted by DHS with noted intractures. Therapy or directives ture and POS/MARs to the identified HS and Primary of facility will be HS and/or ure will ensure by Outcomes ical Meetings. The is in the identified in the identified is in the identified in the id	
	would provide their n On 6/19/18 at 4:30 pi conducted with the A (ADON) who provide sheets for Resident # and stated that when service on 4/19/18 fo nursing was discontir the knees. The last r on 4/5/18. The ADOI was aware occupatio resident's contracted	m an interview was ssistant Director of Nursing d the restorative nursing flow \$27's knee splint placement occupational therapy started or the hand splint, restorative nued for splint placement of restorative nursing note was N acknowledged that she nal therapy worked with the right hand and would not ity splint. The ADON did not		and documentation of con Management and Care Pl documentation/revision. A was provided on 6/28/18 th CCC. New hires will rece F688 during orientation by 3. The monitoring procedu effectiveness of the plan of constitutes monitoring rescontractures for splinting a of care dailyx5, weeklyx5, until next Annual Survey the Findings will be discussed QAPI by the DHS.	tracture an dditional training by the DHS and live education on the CCC.  The to ensure the of correction idents with as continuation then monthly by the DHS.	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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F 689 SS=D	placement treatment.  A review of the weekl revealed that there we that Resident #27 had passive range of moti knee splint for 1-2 hor 4/5/18.  On 6/21/18 at 2:00 pr was interviewed who staff to follow the physical placement.	r received knee splint  y restorative nursing notes as a weekly progress note d received and tolerated on and placement of the curs per day from 10/30/17 to  in the Director of Nursing stated she expected the sician order. ards/Supervision/Devices		688	<ul> <li>4. The person responsible for implementation of the acceptable plan correction: DHS/ADHS/TOC and/or primary nurse.</li> <li>5. Completion date: 7/17/18</li> </ul>	of	7/19/18
	as free of accident has §483.25(d)(2)Each re supervision and assist accidents. This REQUIREMENT by: Based on observation review, the facility fail involving one resident another resident (Resident another residents). The factor as after an earlier when the safe walkway as evaluying on the floor (Residents reviewed findings included:	re that - sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced n, staff interview and record ed to prevent an incident (Resident #55) from hitting ident #3) on the back of the verbal altercation involving acility also failed to provide idenced by an electrical cord esident #75). This was for 2			1. a-Resident #55 and resident #3 have had no further altercations after 1/12/2018. Processes that lead to the deficiency cited were changes in Administrative personnel.  b-On 7/6/2018 Facility Maintenance Director placed tie around PTAC unit coin resident #75□s room. The Maintenan Director secured the tied cord under the PTAC unit and out of the walkway. Processes that lead to the deficiency cowere changes in facility Maintenance	ord nce e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 689	unspecified Schizopl #55's quarterly Minin 12/8/17 indicated he Mental Status (BIMS moderate cognitive i coded for any behav  b. Resident #3 was a cumulative diagnose Resident #3 quarterl indicated a BIMS so cognitive impairment behaviors not directe  Review of a nursing AM read Resident #8 verbal altercation in both residents were Resident #55 went ir Resident #3 was sitt an open hand on the residents were again psychological service Resident #55's medi	sis and later diagnosed with hrenia on 8/14/17. Resident num Data Set (MDS) dated had a Brief Inventory of si) score of 12 indicating impairment and was not iors.  admitted 5/13/14 with its of seizures and dementia. It is of seizures and dementia. It is of 2 indicating severe it and he was coded for ed toward other.  Inote dated 1/12/18 at 9:20 is and Resident #3 had a the hall. The note indicated separated at that time. Into the dining room where ing and hit Resident #3 with the back of the head. Both	F	689	personnel and procedures for monitoring resident environment.  2. a-Facility audit of current residents medical records by Administrator starter-5-2018 and ending 7-10-2018 showed other resident to resident altercations were identified and effectively manage prevent future altercations with other residents. On 6/29/2018 facility employees were educated by Director Health Services regarding identification and management of resident to resident altercations. Facility employees will be trained on identification and management of resident to resident altercations upon hire and annually.  b-Facility Maintenance Director conducted audit starting 7/6/2018 and ending 7/13/2018 of facility PTAC units located in resident care areas. PTAC cords were tied and secured under unit to prevent them from sticking out into walkway. On 6/29/2018 and again on 7/6/2018 facility employees were trained by Director of Health Services and	ed 7 I d to of n t ent n		
	as well as the physic psychological or phy			Administrator respectively on identifica of, reporting, and resolution of possible hazards with emphasis on cords in walkways. Facility administrative team				
	1/12/18 indicated Realtercation with Resi- Resident #55 was pl 24-hours and an in-pwas recommended.	sciplinary Team note dated esident #55's physical dent #3 was discussed. aced on 1:1 supervision for patient psychological consult sciplinary Team note dated a facility request for a			members will monitor rooms for cords walkways daily with negative findings documented on round sheets and reported Monday-Friday in morning administrative meeting. Negative findin will be corrected by Facility Maintenant Director.  3. a- Facility Administrator and/or	gs		

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F 689	Resident #55.  Review of a psychiatr 1/24/18 indicated Resident person and changes made to his regime.  In an interview on 6/1 Assistant (NA)#1 state verbally and physicall residents. She stated things when he was a linear interview on 6/1 stated Resident #55 to physically abusive to recalled an incident with Resident #3 had a verballed and she took Resider was at that time, Resident #3 had a verballed and she took Resider was at that time, Resident 1:1 supervision for Multiple attempts to do by Resident #55.  In an interview on 6/2 Director of Nursing (Emedical leave at the transition of the Assistant DON (ADO nursing department.	ic evaluation note dated sident #55 was seen nit another resident. The ent #55 was alert and d place and there were no medical or medication  9/18 at 3:54 PM, Nursing ed Resident #55 was s y abusive to the staff and he was known to throw angry.  9/18 at 4:00 PM, Nurse #2 was stated verbally and the staff and residents. She when Resident #55 and rbal altercation in the hall. separated the two residents at #3 into the dining room. It ident #55 entered the dining that the staff and residents with the same that the separated the two residents and the staff and residents at #3 into the dining room. It ident #55 was then placed that will be ack of the head. It is in the back of the head. It is includent were refused in the second in the sec	F	589	Department Heads will provide random scenarios to facility staff daily for fourted days, then weekly for two weeks, then monthly where staff must decide if the scenario constitutes an altercation and the actions needed to prevent another occurrence. Results of scenarios and subsequent education will be reported the QAPI Committee meeting monthly ensure compliance.  b- Facility Maintenance Director will randomly audit ten rooms weekly for foweeks then monthly starting 7/16/18 weeks then monthly starting 7/16/18 weeks then monthly starting and subsequent corrections. Maintenance Director will report findings of audits facility QAPI Committee each month to ensure compliance.  4. The facility Maintenance Director and Facility Administrator will be responsible for implementing this plan of corrections. Completion Date: 7/19/18	tell to to to tur ith		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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F 689	incident report was c Resident #55 was pla 24 hours and an atte Resident evaluated a facility that later deni physician and the Ps were notified. There Resident #55's antips In an interview on 6/2 stated it was her exp be monitored for vert involving residents at involved residents be re-occurrence.	vas no evidence that an ompleted on 1/12/18 but acced on 1:1 supervision for mpt was made to have at an inpatient psychiatric ed taking him. She stated the ychiatric Nurse Consultant were new orders to increase	Fé	589		
	revealed Resident #7 clear speech, unders The resident had a macognition. There were issues. The resident assistance of one pelliving except meals wactive diagnoses were pain, muscle weakned lack of coordination.  Resident #75's care goals and intervention code, impaired cognianti-anxiety med, chroassistance for activition On 6/18/18 at 3:08 pand heating unit) corrections.	75 had adequate hearing, stands and was understood. Inoderately impaired are no mood or behavior arequired extensive areas for all activities of daily avere limited assistance. The anemia, anxiety, chronic ass, difficulty walking, and applan dated 6/8/18 revealed ans for at risk for falls, full tion and vision, side effect of conic pain, and extensive				

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F 689 F 692 SS=D	and tripped but did not On 6/19/18 at 8:30 ar observation was done measured approximal lying on the floor next and posed a potential 5 other resident room cord revealed the corunit and not on the floor on 6/19/18 at 3:45 proconducted with the M stated the PTAC wire corrected and placed floor/walkway as required. On 6/20/18 at 2:30 proconducted with the As who stated she expect out of the way of a way Nutrition/Hydration St CFR(s): 483.25(g)(1)-  §483.25(g) Assisted in (Includes naso-gastric both percutaneous endoscenteral fluids). Based comprehensive assessensure that a resident status, sidesirable body weigh balance, unless the resident status, sidesirable body weigh balance, unless the resident status, sidesirable	r did not observe the cord of fall.  In and 1:10 pm an e of the PTAC cord which tely 1/2 inch in diameter was to the bed in the walk way a trip hazard. Observation of s on Hall C for the PTAC d was stored underneath the for in the walkway.  In an interview was aintenance person who for Resident #75 would be under the unit and off the under the unit and off the sistent Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.  In an interview was esistant Director of Nursing steed all electrical wires to be alking area.		689			7/17/18

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F 692	maintain proper hydra §483.25(g)(3) Is offer there is a nutritional provider orders a the This REQUIREMENT by: Based on record revinterview, the facility supplement as ordereresidents reviewed for significant weight loss findings included:  Resident #24 was ad with multiple diagnos quarterly Minimum Didated 4/5/18 indicate severely impaired in a limited assistance with	red sufficient fluid intake to ation and health; red a therapeutic diet when problem and the health care rapeutic diet. To is not met as evidenced liew, observation and staff failed to provide a nutritional ed for one (1) of one (1)	F 6	1.The plan of correction for the deficiency: Resident #24 receiv for Oral Supplements on 6/20/1 Resident also received addition related to oral supplements on Resident remains on WMP. Cal was updated on 6/25/18 by the Process that lead to the cited didentified as response in a time on the part of designated Admir Nurse.  2.The procedure for implementiacceptable plan of correction fo deficiency cited: Audit conducted.	ed orders 8. sal orders 6/25/18. re Plan DHS. eficiency ly manner histrative  ang the or the ed by DHS	
	A care plan last reviewed on 4/19/18 stated Resident #24 had a potential for alteration in nutrition. Approaches included, in part, serve diet as ordered. Monitor intake of diet as ordered. An approach was added on 12/27/17 for a supplemental treat at dinner. Also, an approach was added on 6/17/18 to escort Resident #24 to assisted dining meals with nursing assistant, refer to Registered dietician and add to the weight monitoring program.  A review of Resident #24 's weight revealed the following:			on 6/21/18 related to Recommerelated to currently identified we by RD/CDM. Orders were writted Care Plan revised to reflect current nutritional approaches by the Dadmissions weight will be monitous weekly x4 by the CDM, DHS/AL Restorative Aide. The restorative DHS/ADHS will visually monitous supplements are offered to idented the residents. Licensed staff received in-service training on 6/25/18 by regarding transcription of RD recommendations. Additional en	eight status en with rent HS. New tored DHS, or re Aide and r to ensure ntified ed y the DHS	

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F 692	recommended, in partreat at dinner due to On 12/27/17, Resider order for a supplement due to decreased food A review of the physica 2018, February 2018 May 2018 and June 20 order for a supplement provided at dinner. To discontinue the supplement of the Medica Records (MAR) for James 2018, April 2018 revealed no document nutritional treat to be On 6/20/18 at 8:20AM observed eating bread She was feeding hersencouragement. Nur was fair to good whend during the meal. On 6/20/18 at 11:15 A	n note dated 12/26/17 t, to provide a nutritional decreased intake at dinner.  In #24 had a physician 's natal nutritional treat at dinner d intake at dinner.  It is orders for January, March 2018, April 2018, 2018 revealed there was no natal nutritional treat to be there also was not an order oplemental nutritional treat.  It is a contraction anuary 2018, February 2018, 3, May 2018 and June 2018 natation for the supplemental provided at dinner.  If, Resident #24 was kfast in the dining room. Self with staff sing staff stated her appetite in someone sat with her	F6	692	was provided on 6/28/18 by the DHS a CCC. regarding the 3 step process of checking the POS/MAR with the Medic Record. Return demonstration of the 3 step process was performed by the Licensed Nurses to the DHS and CCC. This process will be utilized for orders obtained and monthly changeover and Care Plan revisions. Each hall will be assigned to DHS, ADHS, and CCC for monitoring. New hires will receive education on F658 during orientation be the CCC.  3. The monitoring procedure to ensure effectiveness of the plan of correction constitutes monitoring orders per Dieta Recommendations daily x5, weekly x5, then monthly until next Annual Survey the DHS. Findings will be discussed in monthly QAPI by the DHS.  4. The person responsible for the implementation of the acceptable plan correction: DHS, ADHS, CCC and/or primary nurse.  5. Completion date: 7/17/18	y the ry		
	conducted with the D Resident #24 had a v	ietary Manager. She stated veight of 145 lbs. when she 6/5/18. A re-weight was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
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F 692	The Dietary Manager weights on 6/11/18. Or ecommendations for supplement 60 millilite addition to the supple Manager stated the swas being placed on dinner meal by the diet. On 6/20/18 at 1:59 Pl conducted with the As She stated suppleme a physician 's order stated suppleme a physician 's order stated suppleme and MAR for the June MAR for the June MAR for the June MAR and stated Resi supplements. She stated supplements were wrand MAR. She said supplements were wrand MAR. She said supplements were wrand MAR. She said supplements were wrand MAR and stated Resi supplements were wrand MAR. She said supplements were wrand MAR. She said supplements were wrand MAR. She said supplements were wrand MAR and stated Resident #24 had a wwould reweigh reside pounds.  On 6/21/18 at 12:17 Feonducted with the Distated there should had order for supplements treat) so it could be make present the supplements treat of the suppl	evealed a weight of 130 lbs. said she received the On 6/17/18, she wrote Standard 2.0 nutritional ers (ml) twice a day in mental treat. The Dietary upplemental nutritional treat Resident #24 's tray at the etary staff.  M, an interview was saistant Director of Nursing. Intal nutrition was written as so they can be monitored.  all record revealed there order for the Standard 2.0 60 e was no documentation on Standard 2.0 supplement.  M, an interview was e #2. She reviewed the June dent #24 was not on any lated that nutritional eitten on a physician 's order she was not aware that regight loss and said they int. Reweight was 131.8	F 6			7/17/18
SS=D	CFR(s): 483.25(i)	, <b>y</b>				

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NAME OF PE	ROVIDER OR SUPPLIER	0.00.0		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 06/2	21/2016
TO UNIC OF TH	TO VIDER OR OUT FEET				04 SOUTH LONG DRIVE		
PRUITTHE	EALTH-ROCKINGHAM				COCKINGHAM, NC 28379		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPIDE DEFICIENCY)			COMPLETION DATE
F 695	Continued From page	2.43		695			
1 000	· -			095			
	§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.  The facility must ensure that a resident who						
	·	e, including tracheostomy					
		ctioning, is provided such					
		professional standards of					
		nensive person-centered					
	1 -	nts' goals and preferences,					
	and 483.65 of this sul						
	This REQUIREMENT is not met as evidenced						
	by:						
	Based on record revi				1.The plan of correction for the specific		
		failed to administer oxygen			deficiency: Resident #58 POS/MAR wa		
		residents reviewed for			updated on 6/18/18 by the primary nurs		
	respiratory care (Res	ident #58).			during Annual Survey. Process that lea		
	Desident #50 was ad	mittad on 6/20/12			to the cited deficiency attributed to lack		
	Resident #58 was ad	milled on 6/30/12			monitoring oversight of Licensed Nurse during monthly changeover.	;S	
	A review of the multi-	disciplinary care conference			daming monthly changeover.		
		on dated 3/2/18 revealed the			2.The procedure for implementing the		
	resident wore his oxy				acceptable plan of correction for the cit deficiency: Medical Record audit was	ed	
	A review of the annua	al Minimum Data Set dated			conducted on residents receiving oxyg	en	
		resident had adequate			by the DHS and primary nurse on 6/29.		
		, and was understood and			The ordered oxygen settings were veri		
	understands. His cog	nition was intact with no			in resident rooms with POS/MAR durin	g	
	behaviors. The resid	ent required one-person			the audit conducted on 6/29/18. The 3		
	physical assistance for	or all activities of daily living.			step process was utilized for medical		
	_	were atrial fibrillation, heart			record, POS/MAR, and Care Plan		
		ictive pulmonary disease,			revisions by the DHS, CCC, and Prima		
	bronchiectasis, and lu	ung abscess.			Nurse. Licensed staff received in-servi	се	
					training on documentation of oxygen		
		itten physician order dated			administration utilizing the 3 step proce		
		ters per minute by nasal			on 6/25/18 by the DHS. Additional train	•	
	cannula as needed.				was provided on 6/28/18 by the DHS a		
	Care plan data d E/OF	/10 revealed the resident			CCC. Return demonstration of the 3 st		
		/18 revealed the resident			process was performed by the License	u	
	full code, supervised	aches for impaired mobility,			Nurses to the DHS and CCC. This process will be utilized for orders obtain	ned	
	iuii coue, supervised	annonci, ilulu voidille			hiocess will be utilized for orders obtain	ieu	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	COMF	E SURVEY PLETED
		345378	B. WING _			1	C / <b>21/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379			21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX		,		
	(MAR) and indicated not on the June 2018 documentation.  On 6/18/18 at 10:40 a conducted with Nurse administration was rethe MAR and signed Resident #58 's June oxygen order. Nurse order from May 2018 the June 2018 month documented on the Market Name 2018 month documented on the Name 2018 month document	e #1 who stated that oxygen quired to be documented on off by nursing each shift. e 2018 MAR was missing the #1 stated that the oxygen was not carried over onto ly physician order and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345378	B. WING _			C / <b>21/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
F 756 SS=E	who stated that she ephysician orders. Drug Regimen Review CFR(s): 483.45(c)(1)(superscript) \$483.45(c)(1) The drumst be reviewed at I licensed pharmacist. \$483.45(c)(2) This resident's median superscript from the resident superscript from	in an interview was irector of Nursing (DON) expected staff to follow w, Report Irregular, Act On (2)(4)(5) imen Review.  In gregimen of each resident east once a month by a view must include a review cal chart.  It is armacist must report any tending physician and the ctor and director of nursing, st be acted upon.  Ide, but are not limited to, any riteria set forth in paragraph an unnecessary drug. In the documented on a cort that is sent to the not the facility's medical of nursing and lists, at a cit's name, the relevant drug, the pharmacist identified. It is in the cord that the identified reviewed and what, if any, in to address it. If there is to medication, the attending ument his or her rationale in		756		7/17/18	
	the resident's medica	1100014.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345378	B. WING		C 06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379	1 00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 756	Continued From pag	e 46	F 75	6	
	maintain policies and drug regimen review limited to, time frame the process and step when he or she ident requires urgent actio This REQUIREMENT by:  Based on record rev Psychiatric Nurse Propharmacy Consultant to act upon recomme Pharmacy Consultant reviewed (Residents The findings included 1. Resident #13 was 4/29/16 with diagnos with behavioral disturdisorder.  A review of Resident revealed an order da (antidepressant med every 8 hours as nee agitation. There was order.  The annual Minimum assessment dated 3/#13's cognition was assessed with verbal and other behavioral Resident #13 was as medication and antided.	actitioner interview, and It interview, the facility failed Endations made by It for 2 of 7 residents #13 and #37).  It:  admitted to the facility on es that included dementia Thance and major depressive  #13 's medical record ted 3/14/17 for Trazodone ication) 12.5 milligrams (mg) Inded (PRN) for anxiety or Indicate the facility of		1.The plan of correction for the specific deficiency: Resident #13 received ord to Discontinue Trazadone on 6/27/18 the primary nurse. Resident #37 received orders to discontinue prn Ativan and Escheduled Ativan for terminal agitation 6/20/18 by the Hospice Nurse during Annual Survey. Process that lead to coto deficiency failure of Licensed Nurse identify importance of discontinuing psychotropic medications per order, last of supervision from Administrative start due to Medical Leave affecting DHS, ADHs, and CCC during calendar year 2. The procedure for implementing the acceptable plan of correction for the codeficiency: Audit conducted by DHS of 6/28/18, for residents receiving prn psychotropic medications. Audit reveatores affected. Identified resider received changes in orders in relation timeframes for the use of these medications. Care Plans and POS/MA received updates related to the identific changes on 6/29/18 by DHS and CRO New admissions to facility will be assessed by the DHS/ADHS and/or	ers by ved degin n on lited es to lick eff . lited n led hts to likes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345378	B. WING		0.6	C 5/ <b>21/2018</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	0/21/2016	
				804 SOUTH LONG DRIVE			
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 756	Physician form dated Resident #13 's Traz been in place since 3 The Pharmacy Consiphysician indicate a contract of Trazodone that include the days. This recommendations responded for Resident #1 were not responded to The Consultant Pharmacy Physician form dated Resident #13 's PRN the Psychiatric Nurse signed and dated the duration of 30 days for This form indicated in order to be written for PRN Trazodone. The clarification order was A review of Resident	macist Communication to 10/18/17 addressed codone PRN order that had 6/14/17 with no stop date. Ultant recommended the duration for the PRN ded documentation of their was to extend beyond 14 andation was not acted upon.  #13 's Drug Regimen ed 11/22/17, 12/18/17, indicated the garding the Trazodone PRN 3 had been resent as they to by the physician.  macist Communication to 13/26/18 that addressed N Trazodone order indicated e Practitioner (PNP) had form on 4/10/18 for a or depression and anxiety. Instructions for a clarification or a specified duration of the e medical record revealed no	F 75	,	ay ordered ceived on 6/25/18 e of proche clays and training DHS and ucation on CCC. ensure the ection cused on x5, weekly all Survey nonthly in		
	3/14/17 for Trazodon PRN for anxiety or ag be no stop date for th A review of Resident 6/1/18 through 6/20/1	e 12.5 mg every 8 hours gitation. There continued to					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		345378	B. WING _			C <b>06/21/2018</b>
	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379	CODE	30.2 20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	Continued From pag	e 48	F 7	756		
	Nursing (DON) on 6/2 reported she had be last couple of month of Nursing (ADON) viduring that time.  An interview was core 6/21/18 at 8:35 AM. Communication to P 10/18/17 and 3/26/13 addressed Resident order that had been stop date were reviewed Recommendations to DRRs for Resident # corresponding Cons Communication to P 11/22/17, 12/18/17, awas asked if that me recommendation for Resident #13 's PRI just unable to locate unable to say for cer received. The ADO Consultant Pharmac Physician form and the Pharmacist Communication of the say for cer received. The ADO Consultant Pharmac Physician form and the pharmacist Communication for	hat corresponded to the 13 and she had not found				
	and had not been ac 3/26/18 that had bee 4/10/18 indicating a reviewed with the AD that included no clar with the ADON. She	ted upon. The form dated en signed by the PNP on duration of 30 days was DON. The medical record ification order was reviewed e stated the PNP or any of the in the form could have written				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 06/21/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		70/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 756	Consultant on 6/21/1 was aware of the reg psychotropic medical duration and that he recommendations re October 2017. The E #13's PRN Trazodo the Pharmacy Consultant of the Pharmacy Consultant of the Pharmacy Consultant of the Pharmacy Consultant outs of these forms to the facility a had not been acted until This interview with the continued. He was a physicians or facility repeat recommendat responded to. He incommended to the had not spoke physicians.  A phone interview was a ware of the regulation and the regulation of the reg	aducted with the Pharmacy 8 at 9:15 AM. He stated he sulation regarding PRN tions being time limited in had been making lated to these orders since DRRs related to Resident ne order were reviewed with litant. The Consultant sication to Physician forms 8/26/18 related to Resident ne order were reviewed with litant. He was informed the lility was unable to locate the lility was unable to locate the lility was unable to locate the lility and the litant Pharmacist hysician forms for the lated 11/22/17, 12/18/17, and le had provided hard copy print lated 11/22/17, 12/18/17, and le had provided all of these and the recommendations upon.  The Pharmacy Consultant lasked if he spoke to the nursing staff regarding ions that were not dicated he informed the DON) or ADON of this issue, an directly to any of the last conducted with the PNP AM. She stated she was on regarding PRN	F 7	56			
	repeat recommendat responded to. He incommended to the incommendation of Nursing (I but he had not spoke physicians.  A phone interview was on 6/21/18 at 10:40 A aware of the regulation psychotropic medical limited duration requires	ions that were not dicated he informed the DON) or ADON of this issue, an directly to any of the as conducted with the PNP AM. She stated she was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345378	B. WING			C 6/21/2018	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 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)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE			
F 756	identify and address orders that had no start and the start and no start and address orders that had no start and address orders that address orders that address and consumple and address and consumple and address. She all of these forms that indicated if a Consult and communication to Presponded to that it we exact reason why be steps to the process Pharmacy Consultar then completed Concommunication to Precommendations, the facility, the facility garden and the forms facility.  An interview was conformed and the forms facility.  An interview was conformed and the forms facility.  An interview was conformed and the forms facility.  The significant change or the significant change and the forms of the significant change and the facility and most recommendations.  The significant change and the facility and most recommendations and the significant change and the significant change and the facility and the facil	working with the facility to any PRN psychotropic top dates. The PRN thad been in place since #13 was reviewed with the this order was one of the ders that had been missed. Sultant Pharmacist hysician forms dated 12/18/17, 1/23/18, and #13 were reviewed with the at Consultant Pharmacist hysician forms related to tions were normally given to reported she responded to at she received. The PNP tant Pharmacist hysician form was not was hard to pinpoint the recause there were many. She explained that the sultant Pharmacist	F 750				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345378	B. WING		C 06/21/2018	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	•	
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F 756	Continued From pag	ge 51	F 756	5		
	receiving hospice se received antianxiety MDS look back perio					
	(antianxiety medicati	dated 5/3/18 indicated Ativan ion) 0.5 milligrams (mg) every PRN) for terminal anxiety for e was no stop date for this				
	Physician form dated be specified for Resi The form additionally to document a ration extend beyond 14 da Resident #37 's phy "agitation" was docu	acist Communication to d 5/9/18 requested a duration ident #37 's PRN Ativan. y indicated the physician was lale if the duration was to ays. This form was signed by sician, dated 5/29/18, and mented on the form. There wided for the PRN Ativan.				
	's order summary in 5/3/18 for Ativan 0.5	t #37 's June 2018 physician cluded the order dated mg every 4 hours PRN. be no stop date for this PRN				
	6/1/18 through 6/19/	t #37 's June 2018 MAR from 18 indicated the PRN order ntinued to be an active order.				
	Consultant on 6/20/1 he was aware of the psychotropic medica duration. He indicate to provide a specific psychotropic medical	nducted with the Pharmacy 18 at 11:05 AM. He stated regulation regarding PRN tions being time limited in ed he expected the physician duration for PRN tions and to document a e duration was to extend				

STATEMENT OF DE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245270	B. WING			С	
NAME OF PROVI	DER OR SUPPLIER	345378	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	06	/21/2018	
	TH-ROCKINGHAM			804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379			
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F 758 Fresh SS=E CF \$4 \$4 afff probution (i) (ii) (iii) (iii) sponsore spon	prising (DON) on 6/2 prisultant Pharmacis ted 5/9/18, signed by sician on 5/29/18 viration for Resident viewed with the DOI is had difficulty worked past and she was complete responsed recommendation. Pected pharmacy reted upon. Pected Pharmacy reted upo	ducted with the Director of 0/18 at 11:55 AM. The st Communication form by Resident #37 's with no documented #37 's PRN Ativan was N. She indicated the facility king with this physician in not surprised by the lack of to the Pharmacy Consultant The DON stated she ecommendations to be chotropic Meds/PRN Use e)(1)-(5)  pic Drugs. notropic drug is any drug that associated with mental ior. These drugs include, drugs in the following	F 7			7/17/18	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		OMPLETED
		345378	B. WING _			C 06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	<b>'</b>	30.2 20 . 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	drugs receive gradual behavioral interventic contraindicated, in an drugs;  §483.45(e)(3) Reside psychotropic drugs punless that medicated diagnosed specific or in the clinical record;  §483.45(e)(4) PRN or are limited to 14 days;  §483.45(e)(5), if the prescribing practition appropriate for the Proposition appropriate for the Proposition appropriate in the reside indicate the duration.  §483.45(e)(5) PRN or drugs are limited to 12 renewed unless the appropriateness. This REQUIREMENT by:  Based on record reversible proposition of the physical failed to ensure physical failed to ensur	ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive for its necessary to treat a condition that is documented and enters for psychotropic drugs is. Except as provided in attending physician or er believes that it is RN order to be extended or she should document their ent's medical record and for the PRN order.  Forders for anti-psychotic and the entertial enter	F 7	1.The plan of correction for the deficiency cited: Resident #13 orders to discontinue Trazado 6/27/18. Resident #10 receive of orders and MAR by DHS are Physician on 6/25/18. No further received and Psychiatric Nurse Practitioner was also updated Resident #37 received orders	received ne on d a review nd Primary ner orders e on 6/25/18.	
	•	readmitted on 2/1/16 with		discontinue prn Ativan and Be Scheduled Ativan for terminal		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			) DATE SURVEY COMPLETED	
		345378	B. WING			C <b>06/21/2018</b>	
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODI	<b>'</b> E	00/21/2010	
				804 SOUTH LONG DRIVE			
PRUITTHE	EALTH-ROCKINGHAM			ROCKINGHAM, NC 28379			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 758	Continued From page	e 54	F 7	58			
	diagnoses that includ			6/20/18 by the Hospice Nurse			
	disorder and psychos	sis. The annual Minimum		Annual Survey. Resident #55	received		
	Data Set (MDS) asse	essment dated 3/16/18		clarified orders on 6/28/18 by			
	indicated Resident #7	10 's cognition was intact.		Process that lead to cited to d			
	She received no antig	osychotic medication during		failure of Licensed Nurses to i	dentify		
	the MDS review period	od.		importance of discontinuing p			
				medications per order, lack of			
		for Resident #10 dated		from Administrative staff due t			
	3/22/18 indicated Ser			Leave affecting DHS, ADHs, a	and CCC		
		rams (mg) twice daily (once		during calendar year.			
		nce in the evening) for seven					
	days then Seroquel 5	60 mg once in the evening.		2.The procedure for implement acceptable plan of correction	-		
	The facility 's Medica	ation Administration Records		deficiency cited: Audit conduc	ted by DHS		
	(MARs) were maintai	ned on hard copy forms. A		on 6/28/18, for residents recei			
	review of the March 2			psychotropic medications. Au			
		d Seroquel 25 mg twice		6 residents affected. Identified			
	daily for 7 days from	3/23/18 through 3/29/18.		receiving prn psychotropic me			
				received changes in orders in			
		dated 3/29/18 indicated an		timeframes for the use of thes			
		#10 's Seroquel to 50 mg		medications. Care Plans and			
		ne morning and once in the		received updates related to th			
	evening).			changes on 6/29/18 by DHS a			
	Desident #10 's Mars	ab 2019 MAD indicated the		New admissions to facility will			
		ch 2018 MAR indicated the		assessed by the DHS/ADHS			
	· ·	r Seroquel 25 mg twice daily		primary nurse for use of psych medications with duration for			
		the MAR after 3/29/18 and el 50 mg once daily that was		prn usage. DHS will oversee r	•		
		completion of 25 mg twice		Pharmacy Recommendations	•		
		discontinued on the MAR on		designated Administrative Nu			
		an 's order dated 3/29/18 for		assist with implementation of			
		e daily was added to the		recommendations for assigne			
	MAR on 3/29/18 and	-		ADHS, and CCC will be assign			
		ing on 3/29/18. The MAR		per DHS directives. Licensed			
	_	stration of 50 mg twice daily		received in-service training by		1	
		dition to the administration of		6/25/18 in relation to monitoring			
		esident #10 ' s Seroquel 50		of prn psychotropic medication	•		
		I twice a day as ordered on		directive of no longer than 14			
	3/30/18 and 3/31/18.			duration, and Care Plan	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345378	B. WING _				C <b>21/2018</b>	
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21/2010	
			804	4 SOUTH LONG DRIVE			
PRUITTHEALTH-ROCKINGHAM			RC	OCKINGHAM, NC 28379			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
physician 's order daidiscontinued on 3/29/daily for Resident #10/2018 MAR was the addated 3/29/18 for Sent This MAR revealed Radministered the disconsistered the disconsistered for Seroquel evening on 4/1/18 and active order for Seroquel evening and 4/2/18.  A physician 's order of increase in Resident at the morning and 100.  The April 2018 MAR worder for Resident #10/4 daily was discontinued. The order for Seroquel discontinued on 3/29/#10 's MAR. The 4/3 mg in the morning and was added in handwrand was initiated on 4/10 from 4/4/18 through active order for Seroquel f	2018 MAR included the ted 3/22/18 that had been 18 for Seroquel 50 mg once 20. Handwritten on the April ctive physician 's order oquel 50 mg twice daily. The sesident #10 was ontinued order dated 50 mg once daily in the day 1/2/18 in addition to the quel 50 mg twice daily on the day 1/3/18 indicated an 1/4/10 's Seroquel to 75 mg in mg in the evening.  Was again reviewed. The 1/3/18 remained on Resident 1/3/18 order for Seroquel 75 day 100 mg in the evening iting to the MAR on 4/3/18 iting to the maximum the puel 75 mg in the morning ening. The discontinued or Seroquel 50 mg once it MAR in handwriting as 1/18 and it was no longer dent #10.	F7	758	documentation/revision. Additional train was provided on 6/28/18 by the DHS a CCC. New hires will receive education F756 during orientation by the CCC.  3. The monitoring procedure to ensure effectiveness of the plan of correction constitutes monitoring medication orde with a focus on psychotropic daily x5, weekly x5, then monthly until next Anni Survey by the DHS. Findings will be discussed in QAPI monthly by the DHS.  4. The person responsible for implementing the acceptable plan of correction: DHS, ADHS, and CCC.  5. Completion Date: 7/17/18	nd on the rs ual		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345378	B. WING		,	C 06/21/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		00/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 758	issues with the reside of antipsychotic med sedation.  An interview was corn Nursing (DON) on 6/2 reported she had bee last couple of months of Nursing (ADON) with during that time.  An interview was corn 6/21/18 at 10:15 AM. physician 's orders as were reviewed with the Resident #10's Sero discontinued as ordered administrations of the She was asked what reviewing orders and to ensure they match were administered as as ordered. The ADO different nurses were the orders and revieweach month. She incorperson responsible for overs revealed she was un previously.  A phone interview was Psychiatric Nurse Praat 10:40 AM. The extension of the sedation o	erroquel revealed no noted ent experiencing side effects ication or excessive iducted with the Director of 20/18 at 11:55 AM. She en out of the facility for the sand the Assistant Director was responsible for her duties inducted with the ADON on The March and April 2018 and MARs for Resident #10 he ADON. She confirmed oquel had not been red resulting in additional entitles in antipsychotic medication.	F7	58			
	as ordered. The ADO different nurses were the orders and review each month. She incorperson responsible for reported that ultimate responsible for overs revealed she was un previously.  A phone interview was Psychiatric Nurse Prat 10:40 AM. The extended the reported to	ON stated that several responsible for reconciling wing the MARS at the end of dicated there was not one or the monthly review. She ely herself and the DON were aware of these errors  as conducted with the actitioner (PNP) on 6/21/18 access administrations of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED			
		345378	B. WING _			C 06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		00/21/2010
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 758	Continued From pag	e 57	F 7	58		
	expected medication ordered and disconti believed Resident #* from the errors.	sage. She stated she s to be administered as nued as ordered, but she lo had no negative effects was conducted with the				
	DON on 6/21/18 at 1	2:10 PM. She stated she s to be administered as				
	4/29/16 with diagnos	admitted to the facility on es that included dementia rbance and major depressive				
	revealed an order da (antidepressant med every 8 hours as nee	#13 's medical record ited 3/14/17 for Trazodone ication) 12.5 milligrams (mg) eded (PRN) for anxiety or s no stop date for this PRN				
	#13 's cognition was assessed with verba and other behavioral Resident #13 was ac medication and antic	n Data Set (MDS) (16/18 indicated Resident s severely impaired. She was I behaviors on 1 to 3 days symptoms on 4 to 6 days. Idministered antipsychotic Repressant medication on 7 MDS look back period.				
	Pharmacy Consultar (DRRs). The DRR d Resident #13 's Traz been in place since 3	cted of Resident #13 's at 's Drug Regimen Reviews ated 10/18/17 addressed codone PRN order that had 3/14/17 with no stop date. ultant recommended the duration for the PRN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345378	B. WING _				21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379			21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
F 758	rationale if the order of days. The DRRs dat 1/23/18, and 3/26/18 recommendations recorder for Resident #1 were not responded to The Consultant Pharmal Physician form dated Resident #13 's PRN the Psychiatric Nurses signed and dated the duration of 30 days for This form indicated in order to be written for PRN Trazodone. The clarification order was A review of Resident 's order summary ind 3/14/17 for Trazodone PRN for anxiety or ago be no stop date for the A review of Resident 6/1/18 through 6/20/1 for Trazodone continuity with no stop date.  An interview was con Nursing (DON) on 6/2 reported she had been last couple of months of Nursing (ADON) with during that time.	ded documentation of their was to extend beyond 14 ed 11/22/17, 12/18/17, indicated the garding the Trazodone PRN 3 had been resent as they to by the physician.  macist Communication to 3/26/18 that addressed I Trazodone order indicated Practitioner (PNP) had form on 4/10/18 for a predepression and anxiety. Instructions for a clarification of a specified duration of the emedical record revealed not swritten.  #13 's June 2018 physician cluded the order dated et 12.5 mg every 8 hours gitation. There continued to	F 7	758			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345378	B. WING			06/	21/2018
	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH LONG DRIVE		
PRUITIH	EALTH-ROCKINGHAM			R	OCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	medications being tir DRRs that addressed PRN order that had be with no stop date we She stated she revier Recommendations the DRRs for Resident # corresponding Const. Communication to Pl 11/22/17, 12/18/17, a was asked if that me recommendation for Resident #13's PRN just unable to locate unable to say for cert received. The ADOI Consultant Pharmacist Communication form and the PNP on 4/10/18 in days was reviewed were located in Resident #10/18 in days was reviewed were record that included in reviewed with the AD any of the nurses who have written a clarification. He indicate recommendations recorders since October Resident #13's PRN in the PRN of the register procession of the register procession of the register procession.	ing PRN psychotropic the limited in duration. The did Resident #13 's Trazodone theen in place since 3/14/17 the reviewed with the ADON. Wed the Pharmacy that corresponded to the 13 and she had not found fultant Pharmacist thysician forms for the thand 1/23/18 reviews. She thant they had not received that for those dates related to the Trazodone, or if she was them. She stated she was them. She stated she was them. She stated she was thain if they had not been the confirmed the 10/18/17 test Communication to the 3/26/18 Consultant thication to Physician form dent #13 's medical record. If 8 that had been signed by indicating a duration of 30 with the ADON. The medical the clarification order was shown. She stated the PNP or to had seen the form could teation order.  Inducted with the Pharmacy 8 at 9:15 AM. He stated he fullation regarding PRN tions being time limited in the had been making lated to PRN psychotropic the 2017. The DRRs related to the Trazodone order were for armacy Consultant. The	F	758			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	· /	MPLETED
		345378	B. WING			C 06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379		7072 1720 10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	related to Resident: were reviewed with was informed the Al unable to locate the Pharmacist Commu for the 11/22/17, 12/ The Pharmacy Consprint outs of these for 12/18/17, and 1/23/ provided all of these This interview with the continued. He was physicians or facility repeat recommendate responded to. He into Director of Nursing to but he had not spoke physicians.  A phone interview with the had not spoke physicians.  A phone interview with the had not spoke physicians.  A phone interview with the had not spoke physicians.  A phone interview with the had not spoke physicians.  The previous distribution of the condense of the regulate physicians and condense that had not stated she had been identify and address orders that had not stated she had been identified that had not stated she had been identified that had not stated she had been identified that had not stated she had b	ded 10/18/17 and 3/26/18 #13 's PRN Trazodone order the Pharmacy Consultant. He DON stated the facility was corresponding Consultant nication to Physician forms (18/17, and 1/23/18 reviews. sultant provided hard copy orms dated 11/22/17, 18. He stated he had forms to the facility.  The Pharmacy Consultant asked if he spoke to the mursing staff regarding thions that were not adicated he informed the (DON) or ADON of this issue, then directly to any of the  Task conducted with the PNP AM. She stated she was ion regarding PRN ations which was a time uiring a documented rationale extend beyond 14 days. She m working with the facility to the any PRN psychotropic top dates. The PRN at had been in place since the #13 was reviewed with the this order was one of the orders that had been missed.	F 75			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345378	B. WING			C <b>06/21/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379	<u> </u>	00/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	psychotropic medica her to address. She all of these forms that indicated if a Consult Communication to Pl responded to that it vexact reason why be steps to the process. Pharmacy Consultant then completed Cons Communication to Pl recommendations, the facility, the facility gacompleted the forms facility.  An interview was cor 6/21/18 at 12:10 PM all PRN psychotropic limited in duration as 3. Resident #37 was 1/8/10 and most recewith multiple diagnos. The significant changassessment dated 4/#37 had severely impreceiving hospice sereceived antianxiety MDS look back period. A physician 's order (antianxiety medication 4 hours as needed (forms).	nysician forms related to tions were normally given to reported she responded to at she received. The PNP cant Pharmacist hysician form was not was hard to pinpoint the cause there were many. She explained that the at completed the DRRs, he sultant Pharmacist hysician forms for lesse forms were given to the we the forms to her, she and then gave it back to the reducted with the DON on She stated she expected a medications to be time per the regulations.  admitted to the facility on ently readmitted on 4/13/18 less that included dementia.  The Minimum Data Set (MDS) 26/18 indicated Resident paired cognition. She was revices and she had not medication during the 7-day	F 7:	58		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345378	B. WING		C <b>06/21/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  804 SOUTH LONG DRIVE  ROCKINGHAM, NC 28379	00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE COMPLETION
F 758	Physician form dated be specified for Resic The form additionally to document a rational extend beyond 14 da Resident #37 's phys "agitation" was docur was no duration proving A review of Resident 's order summary inc 5/3/18 for Ativan 0.5 order.  A review of Resident of A review of Resident 6/1/18 through 6/19/1 for Ativan 0.5 mg con Consultant on 6/20/13 he was aware of the psychotropic medicat duration. He indicated to provide a specific of psychotropic medicat clinical rationale if the beyond 14 days.  An interview was con Consultant on 6/20/13 he was aware of the psychotropic medicated to provide a specific of psychotropic medicated to provide a specific of psychotropic medicated clinical rationale if the beyond 14 days.	cist Communication to 5/9/18 requested a duration lent #37 's PRN Ativan. indicated the physician was ale if the duration was to ys. This form was signed by sician, dated 5/29/18, and mented on the form. There ded for the PRN Ativan.  #37 's June 2018 physician cluded the order dated mg every 4 hours PRN. e no stop date for this PRN  #37 's June 2018 MAR from 8 indicated the PRN order tinued to be an active order.  ducted with the Pharmacy 3 at 11:05 AM. He stated regulation regarding PRN ions being time limited in d he expected the physician duration for PRN ions and to document a e duration was to extend	F 75	,	
	Consultant Pharmacidated 5/9/18, signed physician on 5/29/18 duration for Resident reviewed with the DC	=			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345378	B. WING _			C 06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	ZIP CODE	1 33/2 H2313
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)	DATE
F 758	the past and she was a complete response 's recommendation. expected all PRN psi time limited in duration. 4. Resident #55 was diagnosis of psychosomely diagnosis diagnosis of psychosomely diagnosis diagn	s not surprised by the lack of to the Pharmacy Consultant. The DON stated she sychotropic medications to be on as per the regulations. admitted on 10/3/16 with a sis.  In order dated 11/14/17 read: illigrams (mg) one tablet daily anxiety and agitation for order was written by the onsultant.  Ity Pharmacy Consultant Drug and 11/22/17 made no civan ordered for fourteen here was no documented acy recommendation tinuation of the prn Ativan.  Ity Pharmacy Consultant Drug and 12/19/17 made no civan ordered for fourteen here was no documented acy recommendation tinuation of the prn Ativan.	F7	758		
		ly Pharmacy Consultant Drug ed 1/23/18 made no mention				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION	, ,	ATE SURVEY DMPLETED
		345378	B. WING			C <b>06/21/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 64	F 75	8		
	11/14/17. Review of recommendation to did not include any prn Ativan.	the physician dated 1/23/18 recommendation to stop the				
	read as follows: Ative mouth daily prn for days dated 11/14/1	uary 2018 Physician Orders van 0.5mg one tablet by anxiety or agitation for 14 7. Review of the February d Resident #55 did not receive ivan.				
	Regimen Review da of the prn Ativan ord no documented evid	hly Pharmacy Consultant Drug ated 2/22/18 made no mention der dated 11/14/17. There was dence regarding a pharmacy discontinue the prn Ativan.				
	as follows: Ativan 0 daily prn for anxiety 2018 MAR read Ativ for anxiety dated 2/	h 2018 Physician Orders read .5mg one tablet by mouth dated 2/6/18. The March van 0.5mg one by mouth prn 6/18 and indicated Resident any doses of the prn Ativan.				
		mented evidence of a new ed 2/6/18 regarding Resident				
	Regimen Review da of the prn Ativan wit There was no docu	hly Pharmacy Consultant Drug ated 3/26/18 made no mention th a reorder date of 2/6/18. mented evidence regarding a endation to discontinue the prn				
		2018 Physician Orders read .5mg one tablet by mouth				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345378	B. WING _			C 6/21/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379		0/21/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE			
F 758	MAR read Ativan 0.5 for anxiety effective 2 #55 did not receive a Review of the monthl Regimen Review dat discontinue the prn A automatic stop. Revier recommendation to the stop is the stop of the s	dated 2/6/18. The April 2018 mg one by mouth daily prn 2/6/18 and indicated Resident ny doses of the prn Ativan.  The April 2018 mg one by mouth daily prn 2/6/18 and indicated Resident ny doses of the prn Ativan.  The April 2018 mg of the April 2018 mg one by mouth daily prn 2018 mg of the April 2018 m	F 7	58			
	as follows: Ativan 0.5 daily prn for anxiety of MAR read Ativan 0.5 for anxiety effective 4 #55 received a dose  There was no docum physician order dated #55's prn Ativan.  Review of the monthl Regimen Review dat of the prn Ativan with There was no docum	218 Physician Orders read and one tablet by mouth lated 4/5/18. The May 2018 mg one by mouth daily prn 4/5/18 and indicated Resident of the prn Ativan on 5/8/18.  Lented evidence of a new day 4/5/18 regarding Resident of the prn Ativan on 5/8/18.  Lented evidence of a new day 5/9/18 made no mention a reorder date of 4/5/18.  Lented evidence regarding a dation to discontinue the prn					
	Ativan.  Resident #55's quarte 5/11/18 indicated mo	erly Minimum Data Set dated derate cognitive impairment, ehaviors and rejection of					

		ATE SURVEY DMPLETED				
		345378	B. WING _			C 06/21/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	•	00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 758	was to have gradual instructed by the pha indicated.  Review of the June 2 as follows: Ativan 0.5 daily needed for anxi 2018 MAR read Ativa needed for anxiety et Resident #55 did not doses of Ativan.  In an interview on 6/2 Consultant Pharmaci explain why the time	evised psychotropic dated 5/25/18 indicated he	F 7	58		
	November 2017. He confirmed there was recommendation to the regarding the need to after the original order 11/14/17. He unable new order dates of 20 pharmacy generated MAR. The Consultar aware that any prince time limited in dur continued use with a specifying the duration. In a telephone intervithe Psychiatric Nurse her expectation that the 11/14/17 would have 14 days as ordered.	stated he "missed it." He no documented he facility or the physician of discontinue the prn Ativan er for 14 days dated to state the reason for the /6/18 and 4/5/18 on the monthly orders and monthly he Pharmacist stated he was redication for anxiety must ation or reassessed for the new physician order written on.  ew on 6/21/18 at 10:40 AM, er Practitioner stated it was the Ativan order dated been discontinued after the She stated if continued use ould re-evaluate Resident				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		345378	B. WING				C <b>21/2018</b>
	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE 104 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	1 00/	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 758	In an interview on 6/2 Director of Nursing st that all prn antianxiety time limited in duratio without a reassessme for the medication wit order. QAPI Prgm/Plan, Disc CFR(s): 483.75(a)(2)(2)(2)(2)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)(4)	2/1/18 at 12:10 PM, the ated it was her expectation of medications should be in and no long than 14 days ent for the continued need than new written physician closure/Good Faith Attmpt (h)(i) issurance and performance program.  It its QAPI plan to the State eer than 1 year after the egulation; is of information. Early may not require and of such committee continued to the committee with the section.	F	758	DEFICIENCY)	TE	7/19/18
	by: Based on record revifacility 's Quality Assimprovement committimplemented proceduinterventions that the May 2017. This was	ew and staff interview, the urance and Performance tee (QAPI) failed to maintain ures and to monitor the committee put into place in for three (3) recited can, comfortable, homelike			1. The plan of correction for the specif deficiency cited: a- The bathroom floors in rooms 140, 144, 145, and 148 were deep cleaned the housekeeping supervisor on 6/20/2018 with the caulking around the base of the commode in each room	by	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		, ا	C
		345378	B. WING				21/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIIITTUE	EALTH-ROCKINGHAM			80	04 SOUTH LONG DRIVE		
PROITINE	ALIH-ROCKINGHAM			R	OCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	hazards) which were during the recertificat survey and the currer investigation of 6/21/the facility during the record show a pattern sustain an effective Coincluded:  This tag is cross refers 1. F584-safe, clean, environment: Based interview the facility fabathroom as evidence at the base of the toil observed for environments, and 148).  During the recertificate facility was cited F250 broken chair from Rehalls.	ectancy, free of accident originally cited on 5/11/17 ion/ complaint investigation at recertification/ complaint 18. The continued failure of two federal surveys of a of the facility 's inability to API program. The finding tred to:  comfortable, homelike on observation and ailed to provide a clean ed by a brown ring, soil stain et in 4 of 8 bathrooms ment (Room #s 140, 144, sion survey of 5/11/17, the 3 for failure to remove a sident #86 's room on 1 of 4	F	365	replaced by the facility Maintenance Director on 6/20/2018. On 7/6/2018 ch in resident s room were checked by th Maintenance Director to ensure they w in good working condition. Processes t lead to the deficiency cited were change to administrative personnel as well as changes to environmental monitoring procedures.  b- Resident #37 MDs was correcte on 6/26/18 with J1400 box checked indicating Life Expectancy of six month or less by the Case Mix Coordinator. c- Resident #55 and resident #3 hav had no further altercations after 1/12/2018. On 7/6/2018 Facility Maintenance Director placed tie around PTAC unit cord in resident #75 soon The Maintenance Director secured the tied cord under the PTAC unit and out the walkway. Sigma shields are monito for function and placement daily by fac personnel. Processes that lead to the deficiency cited were changes to the reporting guidelines, facility Maintenan personnel, and environmental monitori	ne ere hat hes d s e d n. of ored ility	
	record review and sta to complete the Minin assessment accurate	41-Accuracy of assessments: Based on d review and staff interview, the facility failed mplete the Minimum Data Set (MDS) ssment accurately in the area of life ctancy (Resident #37) for 1 of 1 residents			procedures.  2. The procedure for implementing the acceptable plan of correction for the	9	
	reviewed for hospice.  During the recertificat facility was cited F278				deficiency cited: a- Facility bathrooms in residents□ rooms were inspected by the housekeeping supervisor starting 6/21/2018 and ending 7/6/2018. Floors	in	
	of restraints, diagnosisms. F689-Free of Accid	•			need of deep cleaning and subsequent caulking were cleaned on the day of the inspection and caulked by facility	t	

Facility ID: 923337

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG		, ا	2
		345378	B. WING			l	21/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDIIITTU	EALTH-ROCKINGHAM			80	04 SOUTH LONG DRIVE		
PROTTER	EALTH-ROCKINGHAW			R	OCKINGHAM, NC 28379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 865	incident involving one from hitting another in back of the head after involving both resident provide a safe walkwelectrical cord laying. This was for 2 of 5 reaccidents.  During the recertificate facility was cited for function and placement period of 16 days foll implementation for a as a significant risk of place.  On 6/21/18 at 12:29 conducted with the Decent place.  On 6/21/18 at 12:29 conducted with the Decent place.  On 6/21/18 at 12:29 conducted with the Decent place.  On 6/21/18 at 12:29 conducted with the Decent place.  On 6/21/18 at 12:29 conducted with the Decent place.  On 6/21/18 at 12:29 conducted with the Decent place.  On 6/21/18 at 12:29 conducted with the Decent place place.	e facility failed to prevent an e resident (Resident #55) esident (Resident #3) on the r an earlier verbal altercation ints. The facility also failed to ay as evidenced by an on the floor (Resident #75). sidents reviewed for tion survey of 5/11/17, the facility also failed to ay as evidenced by an on the floor (Resident #75). sidents reviewed for for a sigma Shield for a owing the date of resident who was identified for wandering to a dangerous for each of Nursing and the firector of Nursing stated, cited in May 2017, corporate sisted with the Plan of the limited amount of time for east POC was possibly a coidents had been a part of and there had been an oring of potential safety had Administrative changes, ordinator which could be a	F	365	bathrooms are cleaned daily by facility housekeeping staff. Bathrooms noted to need deep cleaning or caulking will be placed in facility maintenance log for housekeeping supervisor and Maintenance Director to address. Faciliadministrative employees will note condition of bathroom floors on room round form with negative findings documented on the form and reported during AM meeting to the Maintenance Director and Housekeeping Supervisor Facility employees will be educated on maintaining a clean resident environme with a focus on bathrooms, on 7-6-18 to facility Administrator. Facility employee will receive training on maintaining a clean dannually.  b- Residents receiving hospice services were audited on 6/26/18 and correction were conducted on the MDS in section J100 on 6/26/18 by the Case Mix Coordinator. New residents admitted to facility that meet the criteria for hospice services will receive a Significant Chanassessment conducted by the CMC at time the assessment is due. The DHS visually observe that J1400 is checked Licensed Nurses and Case Mix Coordinator received in-service training the DHS on 6/25/18 in relation to J1400 Additional in-servicing was provided for Non-licensed staff on 6/28/18 by the Di New hires will received education on Fiduring orientation by the CCC.  c- Facility audit of current residents medical records by Administrator starter-5-2018 and ending 7-10-2018 showed	ent, by sean re s s ge the will HS. 641	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED
		345378	B. WING			C <b>06/21/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	)DE	00/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA	DATE
F 865	Continued From page	e 70	F 8	other resident to resident altawere identified and effectivel prevent future altercations we residents. Facility Maintenar conducted audit starting 7/6/ending 7/13/2018 of facility Flocated in resident care area cords were tied and secured to prevent them from sticking walkway. On 6/29/2018 facility were educated by Director on Services regarding identifications. Facility employed trained on identification and of resident to resident altercations. Facility employed trained on identification and of resident to resident altercationed by Director of Health Administrator respectively on of, reporting, and resolution hazards with emphasis on comparison walkways. Facility administration members will monitor rooms walkways daily with negative documented on round sheet reported Monday-Friday in madministrative meeting. Negawill be corrected by Facility Moirector.  3. The monitoring procedure effectiveness of the plan of call the plan o	ely managed with other ince Director /2018 and PTAC units as. PTAC dunder units gout into lity employed of Health ation and resident ees will be management ations upon 2018 and inployees were Services an identification of possible ords in ative team after for cords in the findings its and morning lative finding maintenance et to ensure the correction: It is a to ensure the correction that the correc	s ees ent ent ere und cion es ee the eks be

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG		(X3) DATE S COMPLE	
		345378	B. WING _			C 06/2:	1/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 SOUTH LONG DRIVE ROCKINGHAM, NC 28379	<u>I</u>	00/2	1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 865	Continued From page	e 71	F8	Administrator. b- The facility will monitor da weekly x5, then monthly until r Survey. Findings will be discus monthly in QAPI. Monitoring w conducted by the DHS,CRC,C ADHS. c- Facility Administrator and Department Heads will provide scenarios to facility staff daily f days, then weekly for two wee monthly where staff must decid scenario constitutes an altercathe actions needed to prevent occurrence. Results of scenari subsequent education will be r the QAPI Committee meeting ensure compliance. Facility Ma Director will randomly audit ter weekly for four weeks then mostarting 7/16/18 with reports of findings and subsequent corremaintenance Director will report of audits facility QAPI Committenance Director will report and Administrator was responsible for implementing the correction. b- The facility DHS,CRC,CO ADHS will be responsible for implementing the correction. c- The facility Administrator responsible for implementing the correction. 5. Completion date: 7/19/18.	next Annussed vill be CCC, and/d/or e random for fourter eks, then de if the ation and reported to monthly to aintenance or tooms onthly for negative ections. The complete each of this plan of the complete ection. The complete ection is plan of the complete ection. The complete ection is plan of the complete ection. The complete ection is plan of the complete ection is plan of the complete ection. The complete ection is plan of the complete ection is plan of the complete ection in the complete ection in the complete ection is plan of the complete ection in the complete ection is plan of the complete ection in the complete ection is plan of the complete ection in the complet	en tell to to the see s	