PRINTED: 11/05/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345336	B. WING _				C / <b>27/2018</b>
	ROVIDER OR SUPPLIER	ROANOKE RAPIDS		305	EET ADDRESS, CITY, STATE, ZIP CODE FOURTEENTH STREET ANOKE RAPIDS, NC 27870	1 03	2172010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS	F	000			
F 623 SS=B	was postponed due Notice Requirement	uled for week of 9/11/18 and e to hurricane Florence. BW hts Before Transfer/Discharge 3)-(6)(8)	F€	523			10/15/18
	resident, the facility (i) Notify the reside representative(s) of the reasons for the language and man facility must send a representative of the Long-Term Care Of (ii) Record the reasons discharge in the reasons discharge required (c)(5) of \$483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or continuous discharge required und this section; (B) The health of in be endangered, unthis section;	nsfers or discharges a must- nt and the resident's f the transfer or discharge and move in writing and in a ner they understand. The a copy of the notice to a ne Office of the State mbudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section.  and of the notice. fied in paragraphs (c)(4)(ii) and n, the notice of transfer or under this section must be of at least 30 days before the red or discharged. made as soon as practicable					
ADODATODY	DIDECTORIC OR PROVINC	RISLIPPLIER REPRESENTATIVE'S SIGNATUR	)		TITLE		(X6) DATE

Electronically Signed 10/10/2018

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345336	B. WING			l	27/2018
	ROVIDER OR SUPPLIER	DANOKE RAPIDS	STREET ADDRESS, CITY, STATE, ZIP CODE  305 FOURTEENTH STREET  ROANOKE RAPIDS, NC 27870		05 FOURTEENTH STREET	1 03/	2772010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	under paragraph (c)(10) An immediate train required by the reside under paragraph (c)(10) (E) A resident has no days.  §483.15(c)(5) Content notice specified in paramust include the follo (i) The reason for train (ii) The effective date (iii) The location to what transferred or dischart (iv) A statement of the including the name, 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 Ombourd (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disabiliti	ate transfer or discharge, and (i)(i)(B) of this section; ansfer or discharge is ent's urgent medical needs, and (i)(i)(A) of this section; or the resided in the facility for 30 at so of the notice. The written argraph (c)(3) of this section wing: ansfer or discharge; of transfer or discharge; of transfer or discharge; and the resident is aged; are resident's appeal rights, and information on how form and assistance in and submitting the appeal ass (mailing and email) and the Office of the State budsman; and email address and the agency responsible for vocacy of individuals with a mental sabilities, the mailing and emetal sabilities, the mailing and ephone number of the	F	623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345336	B. WING			09/27/2018		
NAME OF P	ROVIDER OR SUPPLIER	0.0000		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	2//2018	
					05 FOURTEENTH STREET			
SIGNATUI	RE HEALTHCARE OF R	OANOKE RAPIDS			COANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 623	established under th for Mentally III Individual Substitution of the information in the effecting the transfer must update the recias practicable once to become available.  §483.15(c)(8) Notice In the case of facility the administrator of the written notification provided to the State Survey A State Long-Term Cathe facility, and the rewell as the plan for the relocation of the residual the survey A State Long-Term Cathe facility, and the rewell as the plan for the relocation of the residual the survey A State Long-Term Cathe facility and the residual three survey A State Long-Term Cathe facility, and the residual three survey A State Long-Term Cathe facility, and the residual to facility failed to notify writing of the reason	als with a mental disorder e Protection and Advocacy duals Act.  Jes to the notice. The notice changes prior to the or discharge, the facility pients of the notice as soon the updated information  In advance of facility closure closure, the individual who is the facility must provide fror to the impending closure Agency, the Office of the tre Ombudsman, residents of the interviews as the transfer and adequate dents, as required at §  This not met as evidenced  The responsible party (RP) in for the transfer to the	F	623	Written Notification was provided by the Administrator to the three identified residents that were affected by not bei			
	hospital for 3 of 3 reshospitalization (Resi	dent #199, #100 and #11).			provided written notification of discharged Those identified were residents number 199, 100, and 11. This notification was provided to the resident and/or responsible party no later than 10/10/1	ered		
	6/7/18 and had a dia congestive heart failt and Alzheimer 's dis Review of the clinica #199 was transferred	as admitted to the facility on gnosis of hypertension, ure, chronic kidney disease sease.  I record revealed Resident d to the hospital on 7/1/18.  M the Administrator stated in			To insure no other residents were affected, an audit of the current reside population was completed the Administrator with assistance from the Business office Manager on October 5 2018 and notifications were provided f those affected starting the month of	nt		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345336	B. WING			C 09/27/2018	
NAME OF P	ROVIDER OR SUPPLIER	0.0000	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	9/2//2016	
TO UNIC OF T	TO VIDER OR GOT FEILING			305 FOURTEENTH STREET			
SIGNATUR	RE HEALTHCARE OF RO	DANOKE RAPIDS					
				ROANOKE RAPIDS, NC 27870			
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 623	Continued From page	e 3	F 62	23			
	resident/responsible for the transfer and the	I not been notifying the party in writing of the reason nought a phone call was		September 2018. Any identified were corrected by 10/10/18.			
		as admitted to the facility on gnosis of hypertension,		Education on the written notifice discharge policy was provided Administrator and the Director of to all licensed nursing staff as well as wel	by the of Nursing		
	and Alzheimer's dise			business office staff, to include Admissions, Business Office M Assistant Business Office Mana	anager, ager and		
Review of the clinical record revealed Residual #199 was transferred to the hospital on 8/2 On 9/27/18 at 8:50 AM the Administrator st		to the hospital on 8/27/18.  M the Administrator stated in		Social worker. This education v complete by 10/15/18. This trai also be provided to all administ	ning will rative staff		
	resident/responsible for the transfer and the	I not been notifying the party in writing of the reason nought a phone call was		and licensed nursing upon hire orientation.	_		
	sufficient.			Ongoing audits will be complete Administrator or Director of Nur	sing for		
	8/14/14 and had a dia	-		observation and review of prop execution of notification of disc	harge.		
	respiratory failure.	y disease and chronic		These audits will be conducted week for four weeks, weekly for	r three		
	#100 was transferred	record revealed Resident to the hospital on 8/15/18.		weeks, and monthly for three m These audits will also include a discharges for the first seven w	ll eeks of		
	an interview they had	M the Administrator stated in I not been notifying the		audit and then no less than 109 discharges from the center for the months. All data will be sure	the final		
		party in writing of the reason nought a phone call was		two months. All data will be sur and presented to the facility Qu Assurance and Performance Improvement meeting monthly	ıality		
	facility on 2/8/18 with Alzheimer's Disease,	Dysphagia, Difficulty		Administrator. Any issues or tre identified will be addressed by committee as they arise and the	ends the QAPI e plan will		
	Walking, Chronic Ob- Disease, Muscle Wei Infarction. According	akness and Cerebral to the most recent		be revised to ensure continued compliance. The QAPI committ consists of the Administrator, D	tee ON, Staff		
		Data Set dated 2/15/18, d extensive assistance to		Development Coordinator, MDS coordinator, Admission Coordin			

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		345336	B. WING _			C 09/27/2018	
NAME OF PE	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	2112010
SIGNATUR	RE HEALTHCARE OF RO	ANOKE RAPIDS		305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 623	623 Continued From page 4		F 6	323			
	total dependence in n daily.  During an interview of Unit Manager revealed discharged to the hose 8/2/18 for a gastrosto and he was kept in the replacement and he realso revealed Resider to the hospital from 6/6/6/18 through 6/8/18  During an interview of Director of Nursing (Director of Nursing) (Director	nost areas of activities of n 9/27/18 at 10:38 AM the d Resident #11 was spital on 7/30/18 through my (G-tube) replacement e hospital after the G-tube eturned to the facility. She nt #11 was discharged sent /11/16 through 6/16/18 and			Rehabilitation Manager, Medical Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise.		
F 625 SS=B	CFR(s): 483.15(d)(1)(	olicy Before/Upon Trnsfr 2) ped-hold policy and return-	F 6	525			10/15/18
	nursing facility transfer the resident goes on a nursing facility must p the resident or reside specifies- (i) The duration of the	rovide written information to nt representative that state bed-hold policy, if resident is permitted to					

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		345336	B. WING		C <b>09/27/2018</b>	
	ROVIDER OR SUPPLIER	ROANOKE RAPIDS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870		9,2,,,20,10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	plan, under § 447.4 (iii) The nursing fact bed-hold periods, we paragraph (e)(1) of resident to return; a (iv) The information of this section.  §483.15(d)(2) Bed-lithetime of transfer hospitalization or the facility must provide resident represent a specifies the duration described in paragration This REQUIREMENT by:  Based on record refacility failed to provide the facility failed to provide facility failed facility failed to provide facility failed facility failed to provide facility failed facility	payment policy in the state 0 of this chapter, if any; lity's policies regarding which must be consistent with this section, permitting a and specified in paragraph (e)(1)  mold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section.  IT is not met as evidenced eview and staff interviews the ride the bed hold policy at the ne hospital for 3 of 3 residents alization (Resident #199, #100  ed: was admitted to the facility on agnosis of hypertension, lure, chronic kidney disease ease.  all record revealed Resident ed to the hospital on 7/1/18	F 62	Written notification was provi Administrator to the three ideresidents that were affected by provided written bed hold policidentified were residents num 100, and 11. This notification provided to the resident and/oresponsible party no later that To insure no other residents waffected, a full discharge audicompleted by the Administration assistance from the Business Manger on October 5, 2018 to hold policies were provided for affected starting the month of 2018. Any identified during the mailed a copy of the policy as hold agreement documents for by 10/10/18.	ntified by not being cy. Those bered 199, was or n 10/10/18.  were t was or with Office o insure bed or those September is audit, were s well as bed	

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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		345336	B. WING _			09	/27/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SIGNATIII	RE HEALTHCARE OF	ROANOKE RAPIDS		30	05 FOURTEENTH STREET			
SIGNATO	AL IILALIIICANL OI	ROANORE RAFIDS		R	OANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 625	Continued From n	ogo 6	F.	205				
F 023	Continued From p		F 6	325				
		le the bed hold policy at the			Education regarding provision of the			
	time of the transfe	r to the hospital.			written bed hold policy was provided b	У		
					the Administrator and the Director of			
		) AM the Administrator stated in			Nursing to all licensed nursing staff as			
		urse on would contact the family			well as business office staff, to include			
		dent's transfer to the hospital.			Admissions, Business Office Manager			
		stated the resident/family was			Assistant Business Office Manager an	d		
		e bed hold policy in the			Social worker. This education will be			
		and explained to them during			complete by 10/15/18. This training wi			
		cess and upon discharge to the			also be provided to all administrative s	ιаπ		
		nsible party was called to ask if			and licensed nursing upon hire during orientation.			
		d the bed and the information esident's financial folder.			onentation.			
	was noted in the re	esident's financial folder.			Ongoing gudita ware initiated on			
	1h Posidont #100	was admitted to the facility on			Ongoing audits were initiated on 10/5/2018 by the Administrator or Dire	ctor		
		diagnosis of hypertension,			of Nursing for observation and review			
		ailure, chronic kidney disease			proper execution of bed hold policy with			
	and Alzheimer's di				written notice as required. These audit			
		cal record revealed Resident			will be conducted weekly for three week			
		red to the hospital on 8/27/18			monthly for three months and then aud			
	and was admitted.	-			each month for two months. The first	110		
	and was damitted.				three weeks and the first month of			
	On 9/27/18 at 8:43	3 AM the Admissions Director			monthly audits will include all discharg	es.		
		ew if they send a resident to			Following those audits, the audits will a			
		e resident is admitted, they			include no less than 10% of the			
		mily to see if they want to hold			discharges from the center. All data wi	II		
		ssions Director further stated			be summarized and presented to the			
	they did not provid	le the bed hold policy at the			facility Quality Assurance and			
	time of the transfe				Performance Improvement meeting			
		•			monthly by the Administrator. Any issu	es		
	On 9/27/18 at 8:50	) AM the Administrator stated in			or trends identified will be addressed b			
	an interview the nu	urse on duty would contact the			the QAPI committee as they arise and	the		
		ne resident 's transfer to the			plan will be revised to ensure continue	d		
	hospital. The Adm	inistrator stated the			compliance. The QAPI committee			
	resident/family wa	s given a copy of the bed hold			consists of the Administrator, DON, St	aff		
	policy in the admis	sion packet and explained to			Development Coordinator, MDS			
	them during the ac	dmission process and upon			coordinator, Admission Coordinator,			
	discharge to the he	ospital the responsible party			Rehabilitation Manager, Medical Direc	tor,		
	was called to ask i	f they wanted to hold the hed	1		Director of Social Services, and			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345336	B. WING		C 09/27/2018
	ROVIDER OR SUPPLIER	OANOKE RAPIDS	:	STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 625	Continued From pag	ge 7	F 625	5	
	and the information financial folder.	was noted in the resident's		Environmental Services. Other mer may be assigned as the need shou arise.	* * *
	8/14/18 and had a d	as admitted to the facility on liagnosis of chronic lry disease and chronic			
	Review of the clinical record revealed Resident #100 was transferred to the hospital on 8/15/18. On 9/27/18 at 8:43 AM the Admissions Director stated in an interview if they send a resident to the hospital and the resident is admitted, they reach out to the family to see if they want to hold the bed. The Admissions Director further stated they did not provide the bed hold policy at the time of the transfer to the hospital.				
	an interview the nur regarding the reside The Administrator st given a copy of the admission packet ar the admission proce hospital the respons they wanted to hold	AM the Administrator stated in se on duty would the family ant 's transfer to the hospital. Stated the resident/family was seed hold policy in the and explained to them during and upon discharge to the sible party was called to ask if the bed and the information stident's financial folder.			
	facility on 2/8/18 wit Alzheimer's Disease Walking, Chronic Ol Disease, Muscle We Infarction. According Admission Minimum Resident #11 require	s originally admitted to the h diagnoses including e, Dysphagia, Difficulty patructive Pulmonary eakness and Cerebral g to the most recent Data Set dated 2/15/18, ed extensive assistance to most areas of activities of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	OANOKE RAPIDS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	•	3372172010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 625	_	on 9/26/18 at 4:22 PM with	F 6	225			
	#1 revealed when re the hospital she sen administration recor Resuscitate (DNR) of know anything about	he Unit Manager, Staff Nurse esidents were discharged to t a face sheet, medication d (MAR) and Do Not order. She said she did not t a bed hold policy. The Unit ney took care of the bed hold					
	Unit Manager revea discharged to the h 8/2/18 for a gastrost and he was kept in t replacement and he also revealed Resid	on 9/27/18 at 10:38 AM the led Resident #11 was ospital on 7/30/18 through omy (G-tube) replacement he hospital after the G-tube returned to the facility. She ent #11 was discharged sent 6/11/16 through 6/16/18 and 8 for pneumonia.					
	Director of Nursing ( Admissions Coordin residents were disch from her understand	on 9/27/18 at 11:30 AM, the (DON) revealed the ator was notified when harged to the hospital and ling a copy of the bed hold upon the resident's discharge					
	Admission' s Coordi was discharged to the to the family to see it	on 09/27/18 at 08:43 AM, the nator stated when a resident ne hospital, they reached out f they wanted to hold the bed. hold policy was not sent to resident.					
	Administrator stated	on 9/27/18 at 8:50 AM, the residents/responsible a copy of the bed hold policy					

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		345336	B. WING			09/	27/2018
	ROVIDER OR SUPPLIER	DANOKE RAPIDS		30	TREET ADDRESS, CITY, STATE, ZIP CODE 15 FOURTEENTH STREET OANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625 F 640 SS=D	was explained during	tet and the bed hold policy the admissions process. g Resident Assessments		625			10/15/18
	§483.20(f) Automated requirement- §483.20(f)(1) Encodir a facility completes a facility must encode the each resident in the facility facility must encode the each resident in the facility must encode the each resident in the facility assessment (ii) Annual assessment (iii) Significant change (iv) Quarterly review a (v) A subset of items reentry, discharge, and (vi) Background (face is no admission assessment, a facility must be capacted as a facility and that passes standard record layou and that passes standard record layo	In data processing  In g data. Within 7 days after resident's assessment, a the following information for acility: Interpolates. In updates. In it updates. In it updates. It in status assessments. It is assessments. It is assessments. It is a resident's transfer, and death. It is a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to its and data dictionaries, dardized edits defined by  It it is a resident's in a format that conforms to its and data dictionaries, dardized edits defined by  It it is requirements. Within a completes a resident's in must electronically transmit and complete MDS data to luding the following: In in a format that following: In					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED C	
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(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 640	assessment.  (vi) Quarterly review  (vii) A subset of item reentry, discharge, a  (viii) Background (fa initial transmission of does not have an ad  §483.20(f)(4) Data for transmit data in the for a State which has by CMS, in the form approved by CMS.  This REQUIREMEN by: Based on record rev	s upon a resident's transfer, and death. ce-sheet) information, for an f MDS data on resident that amission assessment.  brimat. The facility must format specified by CMS or, is an alternate RAI approved at specified by the State and it is not met as evidenced view and staff interviews, the	F 6	MDS assessments for affected in #1 and #2 were corrected and	residents,		
	facility failed to transmit Quarterly Minimum Data Set (MDS) assessments and a Death in Facility tracking record for 2 of 3 residents (Resident #1 and #2) selected to be reviewed for Resident Assessments.  Findings included:  1. Resident #1 had been admitted on 8/12/14. Her diagnoses included cancer, anemia and hypertension.  a. A Significant Change in Status assessment dated 4/3/18 for Resident #1 was the most recent assessment transmitted to the Centers for Medicare and Medicaid Services (CMS) database.  A review of the facility documentation revealed Resident #1 had a Quarterly MDS assessment dated 6/27/18 completed and marked as accepted on 7/20/18.			resubmitted by the MDS Coordin through Simple LTC for validation acceptance on 9/26/18.  A review and audit of all past MD validation reports from 7/1/18 thr 9/25/18 will be completed to insuother residents were affected. The will be completed by the lead Min Data Set Coordinator (MDSC) and validated by the Administrator and Clinical Reimbursement Consultation 10/15/18. For any identified error corrections were made and were resubmitted by 10/15/2018.  Education to all MSDC Nurses of 10/04/18 by the Regional Clinical Reimbursement Specialist for the This training will also be provided MSDC Nurses upon hire during	n and  OS  rough  Ire no  nis audit  nimum  nd  nd/or the  ant by  rs,  completed  I e region.		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345336	B. WING _				C / <b>27/2018</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	72172010
					05 FOURTEENTH STREET		
SIGNATUR	RE HEALTHCARE OF RO	DANOKE RAPIDS			ROANOKE RAPIDS, NC 27870		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	e 11	F 6	640			
		3 at 12:12 PM an interview was			orientation and annually for review.		
	On 9/26/18 at 12:12 F				onemation and annially for review.		
		DS nurse. She stated a			Ongoing audits will be initiated on 10/4	/18	
	previous MDS nurse				by the Clinical Reimbursement Consul		
	•	ng to the transmission			as well as validation by the Administra		
		quarterly assessment dated			following transmissions of MDS		
	6/27/18 had an error	and had been rejected by			assessments. These audits will be		
		modification had been done			conducted weekly for two weeks, then		
	for this assessment b				monthly for three months. All data will		
	*	een rejected a second time.			summarized and presented to the facil	ity	
		en corrected and the nurse			QAPI meeting monthly by the DON or		
		e whole batch of transmitted			SDC. Any issues or trends identified w		
	assessments as "acc	epted" in the facility system.			be addressed by the QAPI committee		
	On 0/26/19 at 1:44 Di	M an interview with the			they arise and the plan will be revised		
		OON) was conducted. The			ensure continued compliance. The QA committee consists of the Administrator		
		r expectation of the MDS			DON, SDC, MDS coordinator, Admissi		
		essments within the time			Coordinator, Rehabilitation Manager,	OII	
	frames set by CMS, to				Medical Director, Director of Social		
	-	ubmit the assessment. The			Services, and Environmental Services		
	DON also stated it wo	ould be her expectation of			Other members may be assigned as the		
		: mark an assessment as			need should arise.		
	accepted if it had not CMS database.	been accepted into the					
		go in Status accessors at					
		ge in Status assessment dent #1 was the most recent					
	assessment transmitt						
	Medicare and Medica						
	database.	ila col vicco (cime)					
		documentation revealed					
		eath in Facility tracking					
	record dated 7/7/18 h noted as accepted on	nad been completed and 7/20/18.					
	On 9/26/18 at 12:12 F						
	conducted with the M previous MDS nurse	DS nurse. She stated a had submitted this					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345336	B. WING _			C 9/27/2018	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF ROANOKE RAPIDS				STREET ADDRESS, CITY, STATE, ZIP C 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870		3/2//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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 640	report, the resident' error and had been database. The error the nurse must have	ge 12 ding to the transmission s 7/7/18 Death tracker had an rejected by the CMS had not been corrected and e marked the whole batch of ments as "accepted" in the	F 6	540			
	Director of Nursing DON stated it was hurse to transmit as frames set by CMS, inaccuracies and reDON also stated it withe MDS nurse to n	PM an interview with the (DON) was conducted. The ner expectation of the MDS esessments within the time to correct any known submit the assessment. The would be her expectation of ot mark an assessment as of been accepted into the					
	diagnoses included peripheral vascular Annual MDS assess most recent assess	been admitted on 1/16/17. His anemia, hypertension, disease and diabetes. An sment dated 5/2/18 was the ment transmitted to the re and Medicaid Services					
	Quarterly MDS asse	ity documentation revealed a essment dated 7/27/18 had Resident #2 and marked as 8.					
	conducted with the previous MDS nurse assessment. Accord report, the assessment been rejected by the	PM an interview was MDS nurse. She stated a had submitted this ding to the transmission hent had an error and had CMS database. The error had and the nurse must have					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		345336	B. WING		0:	9/27/2018	
	ROVIDER OR SUPPLIER	DANOKE RAPIDS		STREET ADDRESS, CITY, STATE, ZII 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 640 F 657 SS=D	On 9/26/18 at 1:44 Pl Director of Nursing (D DON stated it was he nurse to transmit ass frames set by CMS, t inaccuracies and resi DON also stated it wo the MDS nurse to not accepted if it had not CMS database. Care Plan Timing and CFR(s): 483.21(b)(2)	tch of transmitted epted" in the facility system.  M an interview with the DON) was conducted. The r expectation of the MDS essments within the time o correct any known ubmit the assessment. The buld be her expectation of r mark an assessment as been accepted into the differential Revision  (i)-(iii)		640		10/15/18	
	§483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED  C 09/27/2018		
	345336		B. WING _				
	ROVIDER OR SUPPLIER	OANOKE RAPIDS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	1 33/21/2313		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 657	Continued From pag	e 14	F 6	57			
	team after each assecomprehensive and assessments. This REQUIREMENT by: Based on observation interviews, the facility Care Plan to include urinary catheter for 1 urinary catheter (Resident #199 was a 6/7/18 and re-admitted with a diagnosis of ST The most recent Min Assessment (Quarted the resident had several each of the comprehensive and the several each assessment (Quarted the resident had each assessment (Quarted the resident	essment, including both the quarterly review  T is not met as evidenced on, record review and staff y failed to update a resident's the care for an indwelling of 1 resident reviewed for a sident #199).		The care plan and care card were immediately updated by the Minimu Data Set Coordinator to include a c plan for an indwelling catheter as w indication for catheter care and to u leg band for placement on the care 9/26/18 for the affected resident, #1 In house review completed the Dire Nursing on 10/01/18 of all residents catheter that have the potential to b affected by the deficient practice. It found that no other residents were to be without a care plan and care of were in place with correct information regarding care needs.	are rell as use a card 199. rector of s with a re was found cards on		
	's order dated 9/18/ urinary catheter.  On 9/24/18 at 12:05 observed to have a u at 8:14 AM the reside urinary catheter.  Review of the reside and reviewed on 9/2	I record revealed a physician 18 to place an indwelling  PM, Resident #199 was urinary catheter. On 9/25/18 ent was observed to have a  nt's Care Plan dated 6/7/18 5/18 did not include g the resident 's urinary		Education was completed for all lice nurses and MDS nurses, provided to Director of Nursing. This education complete by 10/15/2018. This trainity also be provided to all nurses and the coordinators upon hire during orient and at least annually.  Ongoing audits will be completed by Director of Nursing or Unit Manager observation and review of care care care plans through daily Clinical When Board meetings as well as through	by the was ng will MDS tation  y the rs for ds and nite		
		he Care Kardex used to egarding resident care for		to ensure care plans and care cards appropriately identify the resident	I		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345336	<b>345336</b> B. WING			1	C <b>09/27/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	2172010	
				3	05 FOURTEENTH STREET			
SIGNATUR	RE HEALTHCARE OF RO	DANOKE RAPIDS			COANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	e 15	F 6	657				
	the nursing assistants information about the for Resident #199.	s (NAs) revealed no care for a urinary catheter			needs. These audits will be conducted days per week for two weeks, then we for two weeks, then monthly for three months. These audits will include any	ekly		
	had a care plan meet	M an interview was DS Nurse who stated they ing with the family yesterday catheter and thought she			affected residents that are admitted wi or have a catheter placed during their stay. All data will be summarized and presented to the facility Quality Assura			
	further stated they ha weekday mornings ar	e catheter. The MDS Nurse d a clinical meeting on nd discussed the orders and			and Performance Improvement meetin monthly by the DON or Staff Developn Coordinator. Any issues or trends	g nent		
		urse stated the nurse on the morning meetings was			identified will be addressed by the QAI committee as they arise and the plan v be revised to ensure continued compliance. The QAPI committee	vill		
	a Care Plan dated 9/2 urinary catheter for R Plan noted the reside due to a Stage 3 or 4	M the MDS Nurse provided 26/18 for an indwelling esident #199. The Care nt had a urinary catheter pressure ulcer in an area nce. One of the approaches er."			consists of the Administrator, DON, SE MDS coordinator, Admission Coordina Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise.	tor, tor,		
	(DON) stated in an in	PM the Director of Nursing terview the care plan should boon as the catheter was						
F 690	interview she had rev clinical meeting dated name was in her note the care plan had bee stated she did not kno	M the DON stated in an iewed her notes from the 19/19/18 and the resident's as and she had checked that en done. The DON further by what happened to the as not on the chart with the	F 6	200			10/15/18	
r 090	DOWE/DIAUGET ITICOTT	inence, Camelei, UTI		บอบ			10/10/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345336	B. WING		C 09/27/2018	
	ROVIDER OR SUPPLIER	DANOKE RAPIDS		STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870		2112010
(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 CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690 SS=D	resident who is continuadmission receives somaintain continence to condition is or become not possible to maintain \$483.25(e)(2)For a resincontinence, based of comprehensive assessed ensure that— (i) A resident who entinuadming catheter is resident's clinical concatheterization was not indwelling catheter or is assessed for removal as possible unless that demonstrates that cathand (iii) A resident who is receives appropriate to prevent urinary tract in continence to the extension of the extensi	nce. cility must ensure that nent of bladder and bowel on ervices and assistance to unless his or her clinical res such that continence is ain. esident with urinary on the resident's assment, the facility must rers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an authorise such that ecessary; ters the facility with an authorise such that ecessary; ters the facility with an authorise such that ecessary; incontinent of bladder treatment and services to rections and to restore ent possible.	F	390		
	restore as much norm possible. This REQUIREMENT by:			The affected resident, #199, was		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	345336		B. WING			C <b>09/27/2018</b>		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 031	2772010	
	10115211 011 001 1 2.2.1				05 FOURTEENTH STREET			
SIGNATUI	RE HEALTHCARE OF RO	DANOKE RAPIDS			OANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
F 690	Continued From page	e 17	F	690				
		r failed to secure an heter for 1 of 1 residents elling urinary catheter			provided a leg band by the charge nurs on the unit immediately on 9/26/18 for catheter tubing to be secured to the bo	the		
	The findings included	<b>:</b>			In house review of all residents with a catheter that have the potential to be affected by the deficient practice was			
	6/7/18 and re-admitte	dmitted to the facility on ed to the facility on 9/12/18			completed by Unit Managers on 09/26/ It was found that no other residents we			
	with a diagnosis of Stage 3 pressure ulcer.				without a catheter leg band.			
	The most recent Minimum Data Set (MDS				Education regarding placement of a leg	3		
	Assessment (Quarter	ly) revealed the resident had			band for residents who require the use	of		
		airment, required extensive			a catheter to all certified nursing			
		th activities of daily living and			assistants and licensed nurses provide			
	was incontinent of bo				by the Director of Nursing and/or the U Manager. This education to be comple			
		n's order dated 9/18/18 to			by 10/15/18. This training will also be			
	place an indwelling u	rinary catheter.			provided to all nurse assistants and licensed nurses upon hire during			
		sident #199 reviewed by the			orientation and at least annually throug	h a		
		activities of daily living noted			skills review.			
	the resident was inco							
	bladder. The Care Plant information regarding				Ongoing audits were initiated on 10/01 and will be continued by the DON,	/18		
		•			Administrator, or Staff Development			
		M, nursing assistant (NA) #1			Coordinator to include observations an	d		
		erved to provide incontinence			review of proper placement of the cath	eter		
		99. There was not a catheter			leg bands for any affected residents.			
		re the catheter. When the			These audits will be conducted 5 days			
	-	e NAs were asked if they			week for two weeks, then weekly for tw			
		ure a urinary catheter. NA #2			weeks, then monthly for three months.			
		s had a catheter strap and			data will be summarized and presented	to to		
		ld not explain why some			the facility Quality Assurance and			
		eter strap and other residents			Performance Improvement meeting	00		
	did not.				monthly by the DON or SDC. Any issue			
	On 0/26/19 at 2:25 D	M the Director of Nursing			or trends identified will be addressed b			
	On 9/26/18 at 2:35 PM the Director of Nursing (DON) stated in an interview she had observed				the QAPI committee as they arise and plan will be revised to ensure continued			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		ľ	(X3) DATE SURVEY COMPLETED  C 09/27/2018	
		345336					
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	<u>'</u>	00,21,2010	$\neg$
CICNATUE	RE HEALTHCARE OF RO	NANOKE BADIDE		305 FOURTEENTH STREET			
SIGNATUR	RE HEALTHCARE OF RO	DANOKE RAPIDS		ROANOKE RAPIDS, NC 27870			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		DATE	I
F 690	Continued From page	e 18	F 6	90			
	Resident #199 with a catheter strap over the weekend. The DON further stated that all residents with an indwelling urinary catheter were supposed to have a leg strap to secure the catheter to prevent pulling on the catheter and the NAs could put these on.			compliance. The QAPI comm consists of the Administrator, MDS coordinator, Admission Rehabilitation Manager, Medi Director of Social Services, at Environmental Services. Other may be assigned as the need arise.	Administrator, DON, SDC, or, Admission Coordinator, Manager, Medical Director, ial Services, and Services. Other members		
F 914 SS=D	Bedrooms Assure Fu CFR(s): 483.90(e)(1)	•	F9	14		10/15/18	
	§483.90(e)(1)(v) In fa March 31, 1992, exce bed must have ceiling extend around the be privacy in combinatio curtains. This REQUIREMENT	designed or equipped to acy for each resident; acilities initially certified after ept in private rooms, each g suspended curtains, which d to provide total visual n with adjacent walls and					
	facility failed to provide residents whose private enough for 2 of 3 hall. The findings included 1. On 9/24/18 at 2:34 closed privacy curtain gap between the end On 9/27/18 at 10:47 of closed privacy curtain gap between the end 2. On 9/24/18 at 2:37 closed privacy curtain gap between the end 2. On 9/24/18 at 2:37 closed privacy curtain gap between the end 2.			Upon identification of deficier affected rooms were fitted wit appropriate sized privacy curt Housekeeping supervisor and Administrator to insure full visof residents.  Facility rounds completed by housekeeping supervisor, madirector and administrator to reach room to ensure the mos sized privacy curtain. Full means provided to DSSI on 10/04/18 quote and timeline for shippin necessary new privacy curtain Estimated return of goods, like	the most tains by the tains by the tains by the tains privacy the intenance measure tappropriate asures to obtain a g of the tains.	te /	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345336	B. WING			C		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		9/27/2018		
NAME OF PI	ROVIDER OR SUPPLIER			, , ,	=			
SIGNATUR	RE HEALTHCARE OF R	OANOKE RAPIDS		305 FOURTEENTH STREET				
				ROANOKE RAPIDS, NC 27870				
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 914	Continued From pag	ne 19	F 91	4				
	On 9/26/18 at 3:57 F	PM in Room # 59 Bed A's		weeks from time of approved	order to			
	closed privacy curtai	n was observed with a 6 foot		receive new curtains in the ce				
	gap between the end	d of the curtain to Bed B.						
				Education was provided by the	е			
	3. On 9/26/18 at 4:00	0 PM in Room # 52 Bed A's		Administrator, the Director of I	Nursing and			
	closed privacy curtai	n was observed with a 5 foot		the Housekeeping Supervisor	to staff			
	• .	d of the curtain to Bed B.		members of the housekeeping				
		AM in Room # 52 Bed A's		maintenance, and nursing dep				
		n was observed with a 5 foot		10/15/2018 to insure understa				
	gap between the end	d of the curtain to Bed B.		appropriate sized privacy curt				
	4 0- 0/00/40 -+ 4-0/	2 DM :- D # 40 D  Al-		place for residents that live in				
		2 PM in Room # 48 Bed A's		This training will also be provided the second of the seco				
		n was observed with a 3 foot do not be defined by the curtain to Bed B.		housekeeping, maintenance a staff upon hire during orientati				
	• .	AM in Room # 48 Bed A's		stair upon tine during offentati	OII.			
		n was observed with a 3 foot		Ongoing audits were started o	n 10/01/18			
		d of the curtain to Bed B.		and will be completed by the A				
	July account and com-			and Housekeeping supervisor				
	5. On 9/26/18 at 4:04	4 PM in Room # 41 Bed A's		curtains meet expectations of				
	closed privacy curtai	n was observed with a 3 foot		met. These audits will be cond	•			
	gap between the end	d of the curtain to Bed B.		times per week for two weeks	, then			
	On 9/27/18 at 10:55	AM in Room # 41 Bed A's		weekly for two weeks, then me	onthly for			
	closed privacy curtai	n was observed with a 3 foot		three months. All data will be	summarized			
	gap between the end	d of the curtain to Bed B.		and presented to the facility Q	uality			
				Assurance and Performance				
		7 PM in Room # 36 Bed B's		Improvement meeting monthly				
		n was observed with a 3 foot		Director Of Nursing or Staff De	•			
	gap from the end of	the curtain to the wall.		Coordinator. Any issues or tre				
	7 On 0/27/19 at 9:50	9 AM in Room # 56 Bed A's		identified will be addressed by committee as they arise and the				
		curtain was not wide enough		be revised to ensure continue	-			
	to provide full visual			compliance. The QAPI commi				
	to provide full visual	privacy.		consists of the Administrator,				
	In an interview on 9/	27/18 at 11:00 AM the		MDS coordinator, Admission (				
		ger stated that on rounds he		Rehabilitation Manager, Medic				
		re full curtains were in place.		Director of Social Services, ar				
	<del></del>	, , , , , , , , , , , , , , , , , , ,		Environmental Services. Othe				
	During an interview	on 9/27/18 at 11:10 AM the		may be assigned as the need				
	Administrator stated she expected full visual			arise.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345336	B. WING _			09/2	; 27/2018
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF ROANOKE RAPIDS				STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870	E	00/2	
(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 CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE
F 914	with their full privacy.	e 20 e in place to provide residents She stated she would ping to hang more curtains.	F9	14			