PRINTED: 11/05/2019 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF ROANOKE RAPIDS SIGNATURE HEALTHCARE OF ROANOKE RAPIDS SIGNATURE HEALTHCARE OF ROANOKE RAPIDS PREFIX TAG PREFIX TAG REACHED-CINCTANUS IS REPRECIBED BY FULL PROVIDERS PLAN CEORGETON REACHED CONTROL MUST BE PRECIBED BY FULL PROVIDERS PLAN CEORGETON REQUIATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments An unannounced Recertification survey was conducted on 9/23/19 through 9/26/19 the facility was found in compliance with requirement CFR482.73 Emergency Preparedness Event ID# 737011. F 000 INITIAL COMMENTS A Recertification and Complaint investigation survey was conducted on 9/23/19 through 9/28/19. Event ID#37011. The survey team entered the facility on 9/23/2019 and exited on 9/28/2019. Additional information was obtained on 10/2/2019. Therefore, the exit dated was changed to 10/2/2019. To facine for exited was changed to 10/2/2019. Therefore, the exit dated was changed to 10/2/2019. Therefore, the exit dated was changed to 10/2/2019. The facility transfers or discharges a resident. The facility transfers or discharges a resident. The facility transfers or discharges a resident. The facility must (I) Notify the resident and the resident's representative(s) of the transfer or discharge and manner they understand. The facility must send a copy of the notice to a representative (s) of the furnisher or discharge and the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section, and (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section, and (iii) Include in the notice the items described in paragraph (c)(5) of this section. | | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ´ | IPLE CONSTRUCTION | L COME | | SURVEY LETED |
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| SIGNATURE HEALTHCARE OF ROANOKE RAPIDS SIGNATURE HEALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEPICIENCY (RACH DESCIDENCY MUST BE PRECEDED BY PULL RECOLATORY OR LISC IDENTIFYING INFORMATION) FREEDLY TAG Initial Comments An unannounced Recertification survey was conducted on 9/23/19 through 9/26/19 the facility was found in compliance with requirement CFR482/73 Emergency Preparedness Event ID# 737/011. FOOD A Recertification and Complaint investigation survey was conducted on 9/23/19 through 9/26/19. Event ID#737/011. The survey team entered the facility or 9/22/19. In 16 of the complaint allegations was substantiated for another resident. F 623 Notice Requirements Before Transfer/Discharge CFR483, 156/(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must. (I) Notify the resident and the resident's representative (5) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must end a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (I) Record the reasons for the mostic modical record in accordance with paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. | | | 345336 | | | | l ' | |
| PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG RECULATORY OR LSC IDENTIFY OR LSC IDE | | | DANOKE RAPIDS | | 305 FOURTEENTH STREET | | | |
| An unannounced Recertification survey was conducted on 9/23/19 through 9/26/19 the facility was found in compliance with requirement CFR482.73 Emergency Preparedness Event ID# 737011. F 000 INITIAL COMMENTS F 000 A Recertification and Complaint investigation survey was conducted on 9/23/19 through 9/26/19. Event ID#737011. The survey learn entered the facility on 9/23/2019 and exited on 9/26/2019. Additional information was obtained on 10/2/2019. Therefore, the exit dated was changed to 10/2/2019. 1 of 16 of the complaint allegations was substantiated for another resident. F 623 SS=B GFR(s): 483.15(c)(3)-(6)(8) \$483.15(c)(3) Notice before transfer/Discharge CFR(s): 483.15(c)(3) Notice before transfer. Before a facility transfer or discharges a resident, the facility must-(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. | PREFIX | (EACH DEFICIENC | CY MUST BE PRECEDED BY FULL | PREFI) | (EACH CORRECTIVE ACCROSS-REFERENCED TO | CTION SHOULD BE O THE APPROPRIA | | COMPLETION |
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| Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. | | - | _ | F 6 | 323 | | | 10/30/19 |
| | | Before a facility transresident, the facility r (i) Notify the resident representative(s) of the reasons for the ranguage and mannefacility must send a crepresentative of the Long-Term Care Om (ii) Record the reason discharge in the residuaccordance with para and (iii) Include in the not paragraph (c)(5) of the | efers or discharges a must- and the resident's he transfer or discharge and move in writing and in a ser they understand. The copy of the notice to a Office of the State budsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section; ice the items described in his section. | | | | | |
| | | | | | TITLE | | | (X6) DATE |

Electronically Signed 10/17/2019

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

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| | | 345336 | B. WING _ | | | C 10/02/2019 |
| | ROVIDER OR SUPPLIER | DANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | • | 10/02/2013 |
| (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 COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 623 | (i) Except as specified (c)(8) of this section, discharge required ur made by the facility a resident is transferred (ii) Notice must be made before transfer or disc (A) The safety of individual be endangered under this section; (B) The health of individual be endangered, under this section; (C) The resident's he allow a more immediate under paragraph (c)(10) An immediate transfer paragraph (c)(10) An immediate transfer paragraph (c)(10) A resident has not days. §483.15(c)(5) Contennotice specified in paragraph (c)(10) The reason for tra (ii) The effective date (iii) The location to with transferred or discharative (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 | d in paragraphs (c)(4)(ii) and the notice of transfer or or order this section must be to least 30 days before the dor discharged. Ade as soon as practicable charge when-viduals in the facility would reparagraph (c)(1)(i)(C) of viduals in the facility would reparagraph (c)(1)(i)(D) of viduals in the facility would reparagraph (c)(3) of this section; after or discharge is ent's urgent medical needs, ent's urg | F6 | 523 | | |

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| NAME OF B | DOLUBER OF OLIDERIES | 345336 | B. WING_ | | • | 0/02/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 305 FOURTEENTH STREET | DDE | |
| SIGNATUI | RE HEALTHCARE OF | ROANOKE RAPIDS | | ROANOKE RAPIDS, NC 27870 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES CNCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 623 | and developmental disabilities, the matelephone number the protection and developmental dis C of the Developmental disorder or related email address and agency responsible advocacy of individes tablished under for Mentally III Indiffecting the transfinust update the reas practicable once becomes available §483.15(c)(8) Noting the case of facilithe administrator of written notification to the State Survey State Long-Term C the facility, and the well as the plan for relocation of the re483.70(I). This REQUIREME | ombudsman; cility residents with intellectual all disabilities or related diling and email address and of the agency responsible for advocacy of individuals with abilities established under Part mental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and at telephone number of the efor the protection and duals with a mental disorder the Protection and Advocacy viduals Act. Inges to the notice. In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon et the updated information | F | 523 | | |
| | 483.70(I). This REQUIREME by: Based on record r | | | Notification was provided to resident that was affected b | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE | | | | | | | |
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| | | 345336 | B. WING _ | | | 1 | 0 2/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | <u> </u> | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 02.20.0 |
| | | | | 30 | 05 FOURTEENTH STREET | | |
| SIGNATUR | RE HEALTHCARE OF R | DANOKE RAPIDS | | | OANOKE RAPIDS, NC 27870 | | |
| (X4) ID PREFIX TAG | IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI) TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 623 | Continued From pag | e 3 | F 6 | 323 | | | |
| | for discharge to hosp representative for 1 of reviewed for hospital Findings included: | of 1 resident (Resident # 75) | | | provided written notification of dischard The identified resident numbered 75. I notification was provided to the resider and/or responsible party no later than 10/18/19. | his | |
| | Resident #75 was readmitted to the facility on 6/19/19 with the following diagnoses: Anemia, Diabetes Mellitus, Non-Alzheimer's Dementia. A review of the most recent MDS (Minimum Data Set) dated 8/23/19 revealed Resident #75 was cognitively impaired with short- and long-term memory issues and high visual impairment. Resident # 75 required extensive assistance from staff with ADLS. A review of physician's orders revealed an order dated 6/15/19 to send resident to hospital for increased heart rate and increased temperature. Resident #75 was readmitted to facility on 6/19/19. An interview was conducted with the Social Worker on 9/25/19 at 4:32 PM and she stated that she was responsible for making sure that the resident representative received a copy of the bed hold policy. An interview conducted with the DON on 9/25/19 at 4:40 PM, revealed discharge notification was done verbally by nursing and documented in the electronic health record (EHR). The DON further stated that she was not aware that written notification was sent to resident representative. A review of the discharge and transfer form revealed resident was discharged to hospital on 6/15/19 and Ombudsman notified on 7/1/19. | | | | All residents have to potential to be affected. An audit of the current reside population was completed and notifications were provided for those affected starting the month of October 2019 and going forward. Education on the written notification discharge policy was provided to all licensed nursing staff, Admissions and Social worker. This education will be complete by 10/18/19. This training wil also be provided to all Admission staff licensed nurses upon hire during orientation. | of I | |
| | | | | | 4. Ongoing audits by the Administrator Director of Nursing for observation and review of proper execution of notification of discharge. These audits will be conducted twice a week for four weeks weekly for three weeks, monthly for the months, and then random audits each month for two months. These audits we also include no less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issue or trends identified will be addressed by the QAPI committee as they arise and plan will be revised to ensure continue | I on s, ree iiii Ii es y the | |

| | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 345336 | B. WING | | C 10/02/2019 |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | |
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| F 623 | resident's status. This REQUIREMEN' by: Based on record rev facility failed to accur Data Set (MDS) asso cognition for 4 of 27 55, and 75) reviewed code for anticoagula reviewed and failed to | nentation of written in representative. To of Assessments. Set accurately reflect the in its not met as evidenced view and staff interviews the rately code the Minimum residents (Resident #9, 17, 14, and failed to accurately ints for 1 of 1 (Resident #4) of code the diagnosis 1 of 3 #27) reviewed for indwelling | F 6 | compliance. The QAPI commiconsists of the Administrator, Development Coordinator, ME coordinator, Admission Coord Rehabilitation Manager, Medic Director of Social Services, ar Environmental Services. Other may be assigned as the need arise. 5. The Administrator and DNS responsible for implementing a maintaining the acceptable placorrection. Corrective action to completed by October 30, 201 | DON, Staff DS inator, cal Director, nd or members should S is and an of to be 19. 10/30/19 y code the 9, #17, #55 Resident #4 nd Resident atheters. d nts #4 and liately ons for |
| | | admitted to the facility on oses to include congestive ertension. | | 2.All residents have the poten affected by this alleged deficient The MDS Coordinator/designed | ent practice. |

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| | | 345336 | B. WING | | | C 10/02/2019 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 0/02/2019 | |
| | | | | 305 FOURTEENTH STREET | | | |
| SIGNATUI | RE HEALTHCARE OF | ROANOKE RAPIDS | | ROANOKE RAPIDS, NC 27870 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | | (X5) COMPLETION DATE | |
| F 641 | (MDS) assessment Brief Interview for N assessment should assessment was le documented. On 9/25/2019 at 1:3 conducted with MD was not employed I assessment was de Resident #9's MDS by the Special Proje and since the BIMS Assessment Refere had to be submitted completed. On 9/25/2019 at 2:3 conducted with the stated she was resi section of the MDS stated she was new | terly Minimum Data Set dated 6/26/2019 revealed a Mental Status (BIMS) be conducted. The ft blank and no score was 38 PM, an interview was S nurse #1, who stated she by the facility at that time the de. The MDS nurse stated assessment was completed ects Consultant on 7/9/2019, was not assessed within the ence Date (ARD), the MDS d without the BIMS section 11 PM, an interview was Social Worker (SW), who ponsible to compete the BIMS assessments. The SW v to the facility and was not ne of Resident #9's BIMS | F 64 | , | e Brief (S) has cation has have an nosis k period. as n MDS tate /17/19. or of 3 veekly x 8 g; then 2 veekly x 4 s MDS ation will a will be ne facility hs by the | | |
| | conducted with the (SPC), who stated a complete the MDS stated the BIMS se nurse or SW as clo could not go past the MDS nurse #2 gave to be completed with the state of the st | O8 AM, an interview was Special Projects Consultant she had come in to help assessments. The SPC ction could be completed by a se to the ARD as possible but nat date. The SPC stated e her a calendar of what was nen she came to the facility, | | Committee as they arise and the be revised to ensure continued compliance. 4. The Administrator and Director Nursing is responsible for impler and maintain the acceptable pla correction. 5. The Administrator and DNS is | r of menting n of | | |
| | | ad already passed and she view the resident after the | | responsible for implementing an maintaining the acceptable plan correction. Corrective action to be | of | | |

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| | | 345336 | B. WING _ | | | C 10/02/2019 | |
| | ROVIDER OR SUPPLIER | DANOKE RAPIDS | | 30 | TREET ADDRESS, CITY, STATE, ZIP CODE 05 FOURTEENTH STREET OANOKE RAPIDS, NC 27870 | 1.0. | <u> </u> |
| (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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 641 | conducted with MDS started working at the only able to keep up assessments, and Renot fall in that catego On 9/26/2019 at 2:03 conducted with the A previous SW had left 2019 and the new SV nurse #1 was new to as well. The Administ | PM, an interview was nurse #2, who stated she a facility in March but was with the Medicare MDS asident #9's assessment did | F | 641 | completed by October 30, 2019. | | |
| | 8/16/2018 with diagn hypertension, diabeted hypertension, diabeted Resident #17's annuary/25/2019 revealed at Status (BIMS) assess The assessment was documented. On 9/25/2019 at 1:38 conducted with MDS was still learning to conducted with MDS was still learning to conthe time Resident #1' The MDS nurse state assessment on 7/31/2 the BIMS section was Social Worker, but shand do the interview Reference Date (ARI already passed. | es and history of a stroke. al MDS assessment dated Brief Interview for Mental sment should be conducted. left blank and no score was PM, an interview was nurse #1, who stated she omplete the assessments at 7's assessment was due. | | | | | |

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| | | 345336 | B. WING _ | | | C 10/02/2019 |
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| F 641 | stated she was ressection of the MDS stated she was new learning how to conwhen Resident #17 On 9/26/2019 at 1:: conducted with MD started working at toolly able to keep usesessments, and did not fall in that conducted with the previous SW had lead to 2019 and the new some swell. The Admir the MDS to be according to the MDS to be according to the MDS to be according to the MDS assessment should assessment was lead to computed. On 9/25/2019 at 1: conducted with MD was new to the fact nurse stated Resident enters and the MDS to the same to the fact nurse stated Resident enters and the MDS to the same to the fact nurse stated Resident enters and the MDS to the same to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the fact nurse stated Resident enters and the MDS to the MDS to the fact nurse stated Resident enters and the MDS to the | Social Worker (SW), who ponsible to compete the BIMS assessments. The SW to the facility and was still inplete the BIMS sections is BIMS assessment was due. 29 PM, an interview was is nurse #2, who stated she he facility in March but was p with the Medicare MDS Resident #17's assessment attegory. 33 PM, an interview was Administrator who stated the left at the beginning of June SW started in July, and MDS to the facility around that time histrator stated she expected urate and completed on time. | F6 | 541 | | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL | | ATE SURVEY DMPLETED | | | | |
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| | ROVIDER OR SUPPLIER | ROANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | • | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 641 | was not assessed in Reference Date (All had to be submitted completed. On 9/25/2019 at 2: conducted with the stated she was respection of the MDS she was new to the how to complete the Resident #55's BIM On 9/26/2019 at 9:0 conducted with the (SPC), who stated complete the MDS stated the BIMS senurse or SW as clocould not go past the MDS nurse #2 gave to be completed who but the ARD had all unable to interview date. On 9/26/2019 at 1:1 conducted with MDS started working at the conducted with MDS started working at the conducted with the started working at the conducted with the started working at the conducted with the previous SW had let 2019 and the new Started working at 2019 and 20 | /2019, and since the BIMS within the Assessment RD) of 7/10/2019, the MDS d without the BIMS section 11 PM, an interview was Social Worker (SW), who ponsible to compete the BIMS assessments. The SW stated of facility and was still learning the BIMS sections when as assessment was due. 108 AM, an interview was Special Projects Consultant she had come in to help assessments. The SPC ction could be completed by a se to the ARD as possible but that date. The SPC stated the her a calendar of what was then she came to the facility, tready passed and she was the resident after the ARD 29 PM, an interview was S nurse #2, who stated she the facility in March but was p with the Medicare MDS Resident 55's assessment did | F | 41 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED C |
|---|---|--|---------------------|--|------------------------------|
| | | 345336 | B. WING | | 10/02/2019 |
| | ROVIDER OR SUPPLIER | ROANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | , |
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| F 641 | expected the MDS on time. | administrator stated she to be accurate and completed | F 64 | | |
| | 7/3/2016 with diagr diabetes and deme | | | | |
| | 7/11/2019 revealed Status (BIMS) asse | rterly MDS assessment dated a Brief Interview for Mental essment should be conducted. as left blank and no score was | | | |
| | conducted with MD was new to the faci MDS nurse stated I assessment was corprojects Consultani BIMS was not asse Reference Date (Al | 38 PM, an interview was S nurse #1, who stated she lity in July 2019. The Resident #75's MDS ompleted by one of the Special ton 8/8/2019, and since the essed within the Assessment RD) of 7/11/2019, the MDS d without the BIMS section | | | |
| | conducted with the stated she was resp section of the MDS stated she was new learning how to cor | 11 PM, an interview was Social Worker (SW), who ponsible to compete the BIMS assessments. The SW v to the facility and was still inplete the BIMS sections 's BIMS assessment was due. | | | |
| | conducted with MD started working at t only able to keep u | 29 PM, an interview was S nurse #2, who stated she he facility in March but was p with the Medicare MDS Resident #75's assessment | | | |

| | | (X3) DATE COMP | SURVEY LETED | | | |
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| | DANOKE RAPIDS | • | 305 | FOURTEENTH STREET | | |
| ID SUMMARY STATEMENT OF DEFICIENCIES EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (| | | (X5) COMPLETION DATE |
| did not fall in that cate On 9/26/2019 at 2:03 conducted with the Adprevious SW had left 2019 and the new SV MDS nurse was new time as well. The Adi expected the MDS to on time. 5. Resident #4 was 2/4/2010 with diagnos hypertension and der Resident # 4's Minima assessment dated 6/cognition was intact a anticoagulant for 7 da period. Resident #4's Physic not reveal anticoagula Resident #4's Medica (MAR) for June 2019 anticoagulants were of On 9/25/2019 at 1:25 conducted with MDS reviewing the Physici anticoagulants was a correct the MDS. On 9/26/2019 at 2:03 | PM, an interview was dministrator who stated the at the beginning of June V started in July, and the to the facility around that ministrator stated she be accurate and completed admitted to the facility on ses to include diabetes, nentia. Jum Data Set (MDS) 19/2019 revealed her and she was on an anys during the look back dian orders for June 2019 did ants were ordered. Justicon Administration Record did not reveal dispensed. PM, an interview was nurse #2 who stated after an orders and MAR, the nerror and she would PM, an interview was | F | 341 | | | |
| | | | | | | |
| | ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC' REGULATORY OR L Continued From page did not fall in that cate On 9/26/2019 at 2:03 conducted with the Ac previous SW had left 2019 and the new SV MDS nurse was new time as well. The Adi expected the MDS to on time. 5. Resident #4 was a 2/4/2010 with diagnos hypertension and den Resident # 4's Minimu assessment dated 6/cognition was intact a anticoagulant for 7 da period. Resident #4's Physic not reveal anticoagulant for 7 da period. Resident #4's Medica (MAR) for June 2019 anticoagulants were conducted with MDS reviewing the Physicia anticoagulants was a correct the MDS. On 9/26/2019 at 2:03 conducted with the Accord conducted cond | REHEALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 did not fall in that category. On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the previous SW had left at the beginning of June 2019 and the new SW started in July, and the MDS nurse was new to the facility around that time as well. The Administrator stated she expected the MDS to be accurate and completed on time. 5. Resident #4 was admitted to the facility on 2/4/2010 with diagnoses to include diabetes, hypertension and dementia. Resident # 4's Minimum Data Set (MDS) assessment dated 6/19/2019 revealed her cognition was intact and she was on an anticoagulant for 7 days during the look back period. Resident # 4's Physician orders for June 2019 did not reveal anticoagulants were ordered. Resident #4's Medication Administration Record (MAR) for June 2019 did not reveal anticoagulants were dispensed. On 9/25/2019 at 1:25 PM, an interview was conducted with MDS nurse #2 who stated after reviewing the Physician orders and MAR, the anticoagulants was an error and she would | ROVIDER OR SUPPLIER RE HEALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 did not fall in that category. On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated the previous SW had left at the beginning of June 2019 and the new SW started in July, and the MDS nurse was new to the facility around that time as well. The Administrator stated she expected the MDS to be accurate and completed on time. 5. Resident #4 was admitted to the facility on 2/4/2010 with diagnoses to include diabetes, hypertension and dementia. 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On 9/25/2019 at 1:25 PM, an interview was conducted with the Surror was tasted after reviewing the Physician orders and MAR, the anticoagulants was an error and she would correct the MDS. On 9/26/2019 at 2:03 PM, an interview was conducted with the Surror and she would correct the MDS. On 9/26/2019 at 2:03 PM, an interview was conducted with the Administration was conducted with the Surror and she would correct the MDS. On 9/26/2019 at 2:03 PM, an interview was conducted with the Surror and she would correct the MDS. On 9/26/2019 at 2:03 PM, an interview was conducted with the Administrator who stated she | A BUILDING 345336 345336 345336 345336 345336 345336 345336 345336 345336 345336 345336 345336 345336 345336 35TREET ADDRESS, CITY, STATE, 2IP CODE 35TREET ADDRESS, CITY, STATE, 2IP CODE 36TREET ADDRESS, CITY, STATE, 2IP CADE 37TRE CADE 37TRE ZIP CADE 37TRE ZIP CADE 37TRE ZIP CADE 37TRE ZIP CADDRESS, CITY, STATE, |

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| | ROVIDER OR SUPPLIER | DANOKE RAPIDS | | 30 | TREET ADDRESS, CITY, STATE, ZIP CODE D5 FOURTEENTH STREET OANOKE RAPIDS, NC 27870 | 1 10/ | 02/2013 |
| (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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 641 | 7/25/2019 with diagnous and congestive heart Resident #27's Physi included orders to choneeded, and catheter shift. No diagnosis from the Physician order. Resident #27's admisdated 8/1/2019 reveas he required total assactivities of daily living urinary catheter. No was included on the Incomplete to | s admitted to the facility on oses to include pneumonia, failure. cian orders dated 7/25/2019 ange urinary catheter as care to be conducted every or the catheter was included ers. sision MDS assessment led her cognition was intact, sistance from staff for g and she had an indwelling diagnosis for the catheter | F6 | 641 | | | |
| F 657 SS=B | nursing staff would be diagnosis. On 9/26/2019 at 2:03 conducted with the Arnew MDS nurse was time of this MDS asse was missed, and she completed accurately Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Comprehe | I Revision (i)-(iii) | F 6 | 657 | | | 10/30/19 |

| | ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | COANOKE RAPIDS | • | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | • |
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| F 657 | Continued From pa | - | F 6 | 57 | |
| | the comprehensive (ii) Prepared by an includes but is not lincludes but resident. (C) A nurse aide wit resident. (D) A member of foo (E) To the extent properties and their resident and their resident and their resident renot practicable for the resident's care plan (F) Other appropriated disciplines as determor as requested by the (iii)Reviewed and reteam after each assessments. This REQUIREMENTS by: Based on record resident. | nterdisciplinary team, that mited to nysician. se with responsibility for the h responsibility for the od and nutrition services staff. acticable, the participation of resident's representative(s). It be included in a resident's e participation of the resident expresentative is determined ne development of the resident expresentative is determined ne development of the resident. Vised by the interdisciplinary essment, including both the quarterly review IT is not met as evidenced view and staff and resident | | 1.The invitation for a care plan | _ |
| | Care Plan meeting t | ty failed to invite a resident to for 1 of 2 residents reviewed plan meeting. (Resident #23) | | was provided immediately and meeting held for Resident #23 10/18/19. | - |
| | on 1/14/16 with diag Weakness (general Obstructive Pulmon Mellitus without com | riginally admitted to the facility gnoses including Muscle (zed), Hypertension, Chronic ary Disease, Type 2 Diabetes aplications and End Stage ording to Resident #23 's | | 2.All residents have the potent affected by the deficient practiplan meetings have been schethe residents that are due in the October and invitations have but 3.Education to the Social Serv Director and MDS nurses prov | ce. Care eduled for all he month of heen mailed. |

PRINTED: 11/05/2019 FORM APPROVED OMB NO. 0938-0391

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S D PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL | | | | | | |
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| | | 345336 | B. WING _ | | | 10// | 02/2019 |
| NAME OF PE | ROVIDER OR SUPPLIER | | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 02/2019 |
| | 10 7.52.1 0.1 00. 1 2.2.1 | | | | , , , | | |
| SIGNATUR | RE HEALTHCARE OF RO | DANOKE RAPIDS | 305 FOURTEENTH STREET | | OANOKE RAPIDS, NC 27870 | | |
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| F 657 | Continued From page | e 13 | F 6 | 57 | | | |
| | Annual Minimum Data Resident #23 had dis altered mental status | organized thinking and | | | MDS nurse consultant. This education was complete by 10/18/19. This training will also be provided to the MDS coordinators upon hire during orientation | - | |
| | 9/23/19. The facility of | e Plan was last revised on ould not find evidence that | | | and at least annually. | | |
| | attend her care plan r | amily member was invited to neeting. | | | Ongoing audits by the Administrator review and validation of care plan invitations through daily PPS meetings | | |
| | family member on 9/2 | vith Resident #23 and her 23/19 at 4:38 PM, Resident ald not recall if she was | | | well as random audits. These audits wi be conducted 5 days per week for two weeks, then weekly for two weeks, ther | II | |
| | | her care plan meeting and out of the hospital. | | | monthly for three months. These audits will include any affected residents that | 3 | |
| | facility Social Worker | n 9/26/19 at 9:42 AM, the stated Resident #23 was ler care plan meeting. The | | | admitted and current resident population. All data will be summarized and present to the facility Quality Assurance and Performance Improvement meeting. | | |
| | Social Worker did not #23 's last care plan | know the date of Resident meeting. | | | monthly by the Social Services Director Any issues or trends identified will be addressed by the QAPI committee as the | | |
| | Director of Nursing (E | ke sure that all invitations to | | | arise and the plan will be revised to ensure continued compliance. The QAI committee consists of the Administrator DON, SDC, MDS coordinator, Admission Coordinator, Rehabilitation Manager, | r, | |
| | Director of Nursing re | n 9/26/19 at 2:00 PM the evealed her expectation was e invited by letter to attend | | | Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as th need should arise. | | |
| | _ | | | | 5. The Administrator and DNS is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by October 30, 2019. | | |
| F 661 SS=B | Discharge Summary CFR(s): 483.21(c)(2)(| (i)-(iv) | F 6 | 61 | 22p.0.002.2y 20.000.00, 20.00. | | 10/30/19 |

| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | | E SURVEY MPLETED |
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| (EACH DEFICIENCE | CY MUST BE PRECEDED BY FULL | ID PREFIX TAG | X (EACH CORRECTIVE ACTION | SHOULD BE | (X5) COMPLETION DATE |
| | | F6 | 561 | | |
| When the facility and must have a dischar but is not limited to, (i) A recapitulation of includes, but is not li of illness/treatment or radiology, and consultii) A final summary of include items in parathetime of the dischardease to authorized the consent of the representative. (iii) Reconciliation of medications with the medications (both prover-the-counter). (iv) A post-discharged developed with the pand, with the resider representative(s), whad just to his or her in post-discharge plan the individual plans to that have been made care and any post-dinon-medical services. This REQUIREMEN by: Based on record revision facility failed to compute discharge summary for discharge. (Resident) | icipates discharge, a resident ge summary that includes, the following: If the resident's stay that mited to, diagnoses, course or therapy, and pertinent lab, ultation results. If the resident's status to agraph (b)(1) of §483.20, at arge that is available for dipersons and agencies, with isident or resident's all pre-discharge resident's post-discharge escribed and If plan of care that is participation of the resident to ew living environment. The of care must indicate where or reside, any arrangements are for the resident's follow up scharge medical and so and staff interviews, the olete a recapitulation of stay for 1 of 1 resident reviewed tent #100). | | summary completed for Resident This recapitulation was completed than 10/18/19. 2.All residents have the potential summary completed for Resident Summary | lent #100. eted no later tial to be | |
| Resident #100 was o | originally admitted to the | | | | |
| | ROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENC REGULATORY OR Summary S' (EACH DEFICIENC REGULATORY OR Continued From page §483.21(c)(2) Dischary the summary of includes, but is not limited to, so includes, but is not limited to, so includes, but is not limited to, so include items in parathetime of the discharge to authorized the consent of the representative. (iii) Reconciliation of medications with the medications (both prover-the-counter). (iv) A post-discharge developed with the pand, with the resider representative(s), whad just to his or her not post-discharge plan the individual plans to that have been made care and any post-dinon-medical services. This REQUIREMENT by: Based on record reversed facility failed to compute discharge summary for discharge. (Resident Regulations) | REHEALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident representative(s), which will assist the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced | ROVIDER OR SUPPLIER RE HEALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 \$483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a recapitulation of stay discharge summary for 1 of 1 resident reviewed for discharge. (Resident #100). | REHEALTHCARE OF ROANOKE RAPIDS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) Continued From page 14 \$483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's status to include items in paragraph (b)(1) of \$483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident's post-discharge medications (both prescribed and over-the-counter). (iii) A consultation of all pre-discharge medications with the resident's consent, the resident to adjust to his or her new living environment. The post-discharge plan of care that is developed with the participation of the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the residents follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete a recapitulation of stay discharges summary for 1 of 1 resident reviewed for discharge. (Resident #100). The findings included: | A BUILDING 345336 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 325 FOURTEENTH STREET ROANOKE RAPIDS. SUMMARY STATEMENT OF DEPICIENCIES EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) Continued From page 14 Continued From page 14 F 661 Continued From page 14 Continued From page 14 F 661 F 661 |

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| | | 345336 | B. WING _ | | | | C 02/2019 |
| | ROVIDER OR SUPPLIER | DANOKE RAPIDS | | 30 | REET ADDRESS, CITY, STATE, ZIP CODE 05 FOURTEENTH STREET OANOKE RAPIDS, NC 27870 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 661 | Continued From page facility on 7/1/19. The home on 7/19/19. During an interview of Director of Nursing (Director of Nursing (Director of Resident #1) During an interview of facility Social Worker the recapitulation of strevealed she did not of stay discharge sund During an interview of DON revealed her expression of stay be done from that day discharge from the factor of the puring an interview of the puring an intervie | e 15 e resident was discharged n 9/26/19 at 12:20 PM, the DON) revealed a discharge summary was not 00. n 9/26/19 at 1:33 PM the , who was responsible for stay discharge summary complete the recapitulation nmary. n 9/26/19 at 2:00 PM, the pectation was that the discharge summary would y forward upon the resident's cility. n 9/26/19 at 2:00 PM, the ing forward when a person the facility a recapitulation | | 661 | recapitulation of stay discharge was completed for those residents discharg in the month of October 2019 and goin forward. 3.Education on the recapitulation of stat discharge summary policy was provide to the Social Services Director. This education will be complete by 10/18/19. This training will also be provided to the Social Services Directors upon hire durorientation. 4.Ongoing audits by the Administrator of Director of Nursing for observation and review of proper execution of recapitulation of stay discharge summar These audits will be conducted twice a week for four weeks, weekly for three weeks, monthly for three months, and then random audits each month for two months. These audits will also include less than 10% of the discharges from the center. All data will be summarized and presented to the facility Quality Assural and Performance Improvement meeting | ed g ay d ering or no he d nce g | |
| | | | | | monthly by the Administrator. Any issue or trends identified will be addressed by the QAPI committee as they arise and plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, State Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Direct Director of Social Services, and Environmental Services. Other member may be assigned as the need should arise. | y the d aff | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED |
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| | | 345336 | B. WING _ | | C 10/02/2019 |
| | ROVIDER OR SUPPLIER | ROANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | 1 10/02/2013 |
| (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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION |
| F 661 | Continued From pa | ge 16 | F 6 | 5.The Administrator and DNS is responsible for implementing and maintaining the acceptable plan correction. Corrective action to be completed by October 30, 2019. | of |
| F 677 SS=D | CFR(s): 483.24(a)(2) A res out activities of daily services to maintair personal and oral h This REQUIREMEN | ident who is unable to carry y living receives the necessary good nutrition, grooming, and | F 6 | 77 | 10/30/19 |
| | interviews the facilit 1 of 3 resident (Resactivities of daily living Findings included: Resident #88 was a 1/31/19 with diagnor hypertension, End Strategy of the most revealed the resident Resident #88 was to dressing, toileting, putransfer. A review of Resident was at risk for selfct | admitted to the facility on ses that included Stage Renal Disease, disease with heart failure. It recent MDS dated 8/30/19 and was cognitively intact. Totally dependent on staff for personal hygiene, bathing and at #88's care plan revealed heare deficit with interventions ance with ADL care, assist | | 1.Nail care was provided for Res#88. 2.To ensure no other residents was affected, an audit of the current repopulation was conducted to valicare was provided. Nail care will provided to newly admitted reside admission if deemed necessary. 3.Education on nail care was prothe licensed nurses and the certification nursing assistants. This education complete by 10/18/19. This trainicals obe provided to all licensed nursing assistants unduring orientation. 4.Ongoing audits by the Unit Marrobservation and validate nail care been provided. These audits will conducted twice a week for four weekly for three weeks, monthly servations. | ere esident date nail be ents upon vided to fied n will be ng will urses pon hire nagers for e has be weeks, |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | IPLE CONSTRUCTION | | X3) DATE SURVEY COMPLETED | |
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| | | 345336 | B. WING _ | | | C 10/02/2019 | |
| | ROVIDER OR SUPPLIER | ROANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CO 305 FOURTEENTH STREET | DDE | | |
| | _ | | | ROANOKE RAPIDS, NC 27870 | | | |
| (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 C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIAT | (X5) COMPLETIC E DATE | ON |
| F 677 | Resident # 88 was i Resident # 88 stated dialysis and that stat The resident was ob brown matter benear During an observati Resident was observati stated that staff are stated that staff are stated that if the resident nail During an interview reported that nails a personal care. An observation on 9 Resident #88 had lob beneath them. During an interview Resident #88 stated someone to cut his stated his nails had because the staff we cut them and never he had a large pair on alls himself. During an interview stated Resident#88 to total care with AD | on on 9/23/19 at 10:35 am, in his room lying in bed. In his room lying in his and with nails on both hands. In his room 9/24/19 at 8:43 am, wed to have long fingernails eneath nails. In his room 9/24/19 at 8:43 am, wed to have long fingernails eneath nails. In his room 9/25/19 at 9:55 AM NA#1 to look at nails daily. She ident is a diabetic or has in the NA reports to the nurse lis need to be trimmed. In his room 9/25/19 at 10:35 AM NA#4 are to be looked at daily during his returned belooked at daily during his room 9/25/19 at 2:13 PM at a till the was hard to get fingernails. Resident #88 to be cut by family members ould say they were going to returned. Resident #88 stated of nail clippers and had cut his on 9/25/19 @2:22 PM NA#2 required extensive assistance bus. NA#1 stated Resident#88 | F | months, and then random at month for two months. Thes include 10 residents per aud be summarized and present facility Quality Assurance an Performance Improvement in monthly by the Administrator or trends identified will be act the QAPI committee as they plan will be revised to ensur compliance. The QAPI committee compliance. The QAPI committee of the Administrator Development Coordinator, in coordinator, Admission Coordinator, Admission Coordinator, Admission Coordinator of Social Services, and Environmental Services. Oth may be assigned as the need arise. 5. The Administrator and DN responsible for implementing maintaining the acceptable progrection. Corrective action completed by October 30, 26 | te audits will dit. All data we ted to the and meeting r. Any issues ddressed by v arise and the e continued mittee r, DON, Staf MDS rdinator, dical Directo and her members ed should S is g and plan of t to be | s ne f r, | |
| | | lependently with setup help. | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | PLE CONSTRUCTION G | | MPLETED |
|--------------------------|---|--|---------------------|---|--------|----------------------------|
| | | 345336 | B. WING _ | | | C 10/02/2019 |
| | ROVIDER OR SUPPLIER | OANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | | 10/02/2013 |
| (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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 690 SS=E | as she could during I did not have time to pass it on to the next During an interview of stated staff are to loo provide nail care. NA care was documented shift. An interview was cong/26/19 at 11:02 AM. Resident #88 was also stated Resident #88 staff for all care and cut his own nails due. An observation cond Nursing (DON) on 9/revealed that Reside with brown matter be DON stated she wou immediately. Bowel/Bladder InconcTFR(s): 483.25(e)(1); §483.25(e) Incontine §483.25(e)(1) The faresident who is continuadmission receives simaintain continence condition is or beconnot possible to mainter | she attempted to do as much her shift. She stated if she complete nail care she would the shift. In 9/25/19 @ 2:30 PM NA# 3 ok at resident nails daily and with a stated that all resident and in the Kiosk by staff each and ucted with Nurse #2 on and Nurse #2 stated that ert and with it. He further was totally dependent on there was no way he could be to left hand weakness. In word with Director of 126/2019 at 11:23 AM and #88 had long fingernails eneath to his right hand. The wild get that taken care of 126/2019 at 13:23 AM and the state of 126/2019 at 13:23 AM and the state of 126/2019 at 13:23 AM and get that taken care of 126/2019 at 13:23 AM | F 6 | | | 10/30/19 |
| | §483.25(e)(2)For a ruincontinence, based comprehensive asse | | | | | |

PRINTED: 11/05/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE COMP | SURVEY LETED |
|---|--|--|--|-----|---|-----------------------|----------------------------|
| | | 345336 | B. WING | | | | 02/2019 |
| NAME OF PF | ROVIDER OR SUPPLIER | 0.000 | 1 | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/1 | 02/2019 |
| SIGNATUF | RE HEALTHCARE OF RO | DANOKE RAPIDS | | | 05 FOURTEENTH STREET COANOKE RAPIDS, NC 27870 | | |
| (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 690 | indwelling catheter is resident's clinical concatheterization was not (ii) A resident who en indwelling catheter or is assessed for remoras possible unless the demonstrates that call and (iii) A resident who is receives appropriate prevent urinary tract is continence to the extremely continence, based comprehensive assessment that a resident receives appropriate restore as much normal possible. This REQUIREMENT by: Based on observation and resident interviewensure a resident had condition for the use catheter for 1 of 3 resident for 1 of 3 resident #27 was ad 7/25/2019 with diagnostical resident #2 | ters the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's assment, the facility must the who is incontinent of bowel treatment and services to nal bowel function as is not met as evidenced on, record review, and staff we, the facility failed to dia diagnosis or clinical of an indwelling urinary sidents (Resident #27) s. it: mitted to the facility on oses to include bacteremia, (UTI), pneumonia, and | F | 690 | 1.The affected resident, #27 foley catheter has been removed and reside will be seen by the urologist on 10/25/1 2.In house review of all residents with a catheter that have the potential to be affected by the deficient practice was completed by 10/18/19. It was found the no other residents were affected. New admitted residents with indwelling catheters will be reviewed to ensure earesident has a diagnosis/clinical condition the use of an indwelling catheter and/or have the indwelling catheter | 9. a nat lly | |

| | AN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP | | (X3) DATE SURVEY COMPLETED | | |
|---------------|--|--|-------------------------------|--|---------------------------------------|
| | | 345336 | B. WING | | C 10/02/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/02/2013 |
| | | | | 305 FOURTEENTH STREET | |
| SIGNATU | RE HEALTHCARE OF F | ROANOKE RAPIDS | | ROANOKE RAPIDS, NC 27870 | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | |
| PREFIX TAG | , | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | |
| F 690 | Continued From pa | ge 20 | F 690 | | |
| | | spital discharge summary of the resident completed a | | removed. | |
| | 15-day course of int | travenous antibiotics for | | 3.Education to all licensed nurses | |
| | pneumonia and urin | ary tract infection. An | | provided by the Director of Nursing ar | nd/or |
| | additional note read | l, "Family asking that | | the Unit Manager. This education to b | e |
| | (catheter) be continu | ued, for patient comfort and | | complete by 10/18/19. This training w | ill |
| | _ | ncreases patient skin tears | | also be provided to all licensed nurse | S |
| | | liagnosis was included on the | | upon hire during orientation. | |
| | summary for the use | e of the catheter. | | | |
| | | | | 4.Ongoing audits by the DON or Staff | |
| | | rders dated 7/25/2019, for | | Development Coordinator to validate | |
| | | ded to change the catheter as | | residents with an indwelling catheter I | |
| | | , blockage or dislodgment, | | a diagnosis/clinical condition for the u | |
| | | very shift. There was no | | an indwelling catheter and/or have the | |
| | order for the use of | attached to the Physicians | | indwelling catheter removed. These a will be conducted 5 days per week for | |
| | order for the use of | the catheter. | | weeks, then weekly for two weeks, the | |
| | A Physician progres | ss note dated 7/27/2019 did | | monthly for three months. All data will | be |
| | not address the resi | ident's indwelling catheter. | | summarized and presented to the fac Quality Assurance and Performance | ility |
| | Resident #27's adm | ission Minimum Data Set | | Improvement meeting monthly by the | |
| | (MDS) assessment | dated 8/1/2019 revealed her | | DON or SDC. Any issues or trends | |
| | cognition to be intac | ct. She required extensive to | | identified will be addressed by the QA | νPI |
| | total assistance fron | n staff for activities of daily | | committee as they arise and the plan | will |
| | living, and she had | an indwelling catheter. There | | be revised to ensure continued | |
| | _ | in the assessment to support | | compliance. The QAPI committee | |
| | | lling catheter. The Care Area | | consists of the Administrator, DON, S | |
| | , , | included a family interview | | MDS coordinator, Admission Coordin | · · · · · · · · · · · · · · · · · · · |
| | - | catheter for comfort. No | | Rehabilitation Manager, Medical Direct | ctor, |
| | | hed to the CAA for a clinical | | Director of Social Services, and | |
| | reason for use of the | e catneter. | | Environmental Services. Other memb | ers |
| | A Dhyaiain nas | note dated 0/10/0010 4:4 | | may be assigned as the need should | |
| | | ss note dated 9/12/2019 did ident's indwelling catheter. | | arise. | |
| | | - | | 5.The Administrator and DNS is | |
| | Resident # 27's care | e plan, dated 8/1/2019, | | responsible for implementing and | |
| | included a problem | of an indwelling catheter, with | | maintaining the acceptable plan of | |
| | a goal of no UTI's o | r urethral trauma. | | correction. Corrective action to be | |
| | Interventions for the | indwelling catheter included | | completed by October 30, 2019. | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | | DATE SURVEY COMPLETED | |
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| | | 345336 | B. WING | | | C 10/02/2019 | |
| | ROVIDER OR SUPPLIER | OANOKE RAPIDS | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | | ' | 10/02/2013 | |
| (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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 690 | an assessment for cleast quarterly. On 9/23/2019 at 10:3 conducted with Resinot know why she have bathroom. The residissues or complication having the indwelling. On 9/25/2019 at 12:3 conducted with Nurs#27. The Nurse stat#27's catheter was fidid not know of a voifor Resident #27. The sample had recently see if Resident #27 were not available your on 9/26/2019 at 11:3 catheter care was of nursing assistant #5 were noted at or aro On 10/2/2019 at 3:4 conducted with MDS not have a diagnosis #27 when she was wassessment and she of Nursing (DON) availagnosis. The MDS family interview for the resident comfort and included in the Care On 10/2/2019 at 3:5 | an an interview was dent #27 who stated she did ad the catheter, but it was she couldn't walk to the dent was unaware of any ons she experienced from a catheter. 27 PM an interview was e #1 who cared for Resident for urinary retention, but she ding trial that had been done the nurse stated a urine been sent for a culture to had a UTI, but the results et. 36 AM, an observation of observed for Resident #27 with No bruising or skin tears und insertion site. | F 69 | 90 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | 345336 | B. WING | | C 10/02/2019 |
| | ROVIDER OR SUPPLIER | DANOKE RAPIDS | | STREET ADDRESS, CITY, STATE, ZIP CODE 305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870 | 10/02/2013 |
| (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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| F 867 SS=B | stated she made an a Urologist for resident UM stated when a rea a clinical need for an resident would be seinstruction. The UM for Resident #27's un appointment because follow up ordered for On 9/26/2019 at 12:5 conducted with the D who stated she started approximately one madiagnosis for Resident was admitted order for a trial remove could not find any assince admission. The the admitting nurse to diagnosis and need for resident was admitted QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality assurance committee (ii) Develop and impleaction to correct iden This REQUIREMENT by: Based on staff intervice facility's Quality Asse Committee failed to a procedures and monicommittee put into place. | appointment with the #27 for 10/15/2019. The sident was admitted without indwelling catheter the nt to the urologist for further stated she was not the UM it but made the urologist e she saw there was not the catheter. O PM, an interview was irector or Nursing (DON) ed working at the facility onth ago and could not find ent #27's catheter, or an val. The DON stated she sessments for the catheter e DON stated she expected o obtain an order for the or a catheter when the d. elent Activities (iii) sesessment and assurance. rallity assessment and e must: ement appropriate plans of tified quality deficiencies; is not met as evidenced riews and record review, the ssment and Assurance naintain implemented tor the interventions the | F 86 | | itor |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 345336 | B. WING | | | | 00/0040 |
| NAME OF D | ROVIDER OR SUPPLIER | 343330 | 5: ***** | | REET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 02/2019 |
| NAIVIE OF P | ROVIDER OR SUPPLIER | | | | | | |
| SIGNATU | RE HEALTHCARE OF RO | DANOKE RAPIDS | | | 5 FOURTEENTH STREET | | |
| | | | | RO | DANOKE RAPIDS, NC 27870 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 867 | Continued From page | e 23 | F 8 | 367 | | | |
| F 007 | deficiency which was recertification survey of Requirements before F-623. The continue two federal surveys of the facility's inability to Assessment and Ass | recited during the of 9/26/19 regarding Notice ore Transfer/Discharge, d failure of the facility during of record shows a pattern of to sustain an effective Quality trance program. I: referenced to: interviews and medical ed to provide written notice ge to hospital to resident of 1 resident reviewed for dent #75) cited on 9/27/18 for failing to a party (RP) in writing of the the hospital for 3 of 3 | FE | 367 | place on September 27, 2018. The Quassurance Performance Improvement (QAPI) team notified Medical Director 10/11/19 and held a discussion with the QAPI team regarding the findings of the recertification survey. An Ad Hoc QAPI team meeting was held on 10/11/19 regarding the plan of correction and the involvement of the QAPI team to ensure the identified concern is corrected and maintained in compliance. 2. Residents in the facility have the potential to be affected by the alleged deficient practice. 3. The Quality Assurance Performance Improvement Committee will ensure the Discharge Summaries are completed regarding the Notice of Requirements before Transfer/Discharge F-623. Education completed regarding the Notice of Requirements of the Notice | on e e e e e re | |
| | Administrator revealed team and none of the were in the facility last reference to the correlate at the goals. She discharged to the host called and the next domeeting and a form with She revealed she did she could not keep it the ombudsman log at did not know about the to be sent to family means and not she could not family means. | on 9/26/19 at 2:40 PM, the ed the facility had a new e staff in the facility this year st year. She revealed in ections from last year, they goals and interventions to stated before a resident was epital the medical doctor was ay they had stand up was completed and mailed. I not know about the form so going, but she knew about and she kept it up, but she he letter that was supposed hember after a resident was epital, otherwise she would | | | of Requirements before Transfer/Discharge by 10/18/19 to the admission coordinator and Social Worl 4.The QAPI Committee will review rest of written notice of reason for discharg audits during the monthly meetings. Audits will be completed on 3 discharg residents weekly x 8 weeks to ensure written notice of reason for discharge t hospital to resident representative have been issued; then 2 discharged resident weekly x 4 weeks: the 1 discharged resident monthly thereafter. Any issues trends identified will be addressed by t QAPI committee as they arise and the plan will be revised to ensure continue | ults e ed o e nts s or | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DAT | (X3) DATE SURVEY COMPLETED | |
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| | | 345336 | B. WING | | 1 | C 0/02/2019 | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 1 | 3/02/2019 | |
| | | | | 305 FOURTEENTH STREET | | | |
| SIGNATURE HEALTHCARE OF ROANOKE 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 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 867 | Continued From page have kept it up. | | F 86 | DEFICIENCY) | | | |
| | | | | | | | |