STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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
E 000	Initial Comments An unannounced Recertification/Complaint Investigation suvey was conducted on 11/18/19 through 11/22/19. The facility was found in compliance with the required CFR 483.73, Emergency Preparedness. Event ID# C9I011.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey were conducted from 11/18/19 through 11/22/19 at event ID# C9I011. 1 of 1 complaint allegation was unsubstantiated. A recertification survey and complaint investigation survey were conducted from 11/18/19 through 11/22/19. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/19/19 and was removed on 11/21/19. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		1/6/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interviews, and record review, the facility failed to treat a resident with dignity and respect by labeling a resident who required assistance with meals as a "feeder" and providing a meal tray to a resident 20 minutes prior to the rest of the	F 550	Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 550	Continued From page 2 residents eating in the dining room. This was evidenced in 2 of 2 residents observed for dignity. (Resident #80 and Resident #65) Findings included: 1. Resident #80 was admitted to the facility on 10/13/16. His active diagnosis included hypertension and depression. A review of Resident #80's minimum data set assessment dated 10/17/19 revealed he was assessed as cognitively intact. He was also assessed to be totally dependent on staff for eating. A review of Resident #80's care plan dated 10/25/19 revealed he had a care plan for requiring total care for eating. During observation on 11/18/19 at 12:40 PM Nurse Aide #1 was standing in the hallway next to the meal cart on the 100 hall. Nurse Aide #2 was in a room on the 100 hall approximately two doors down from the meal cart on the hall. Nurse Aide #1 was observed to turn and walk down the hall in the direction of the nursing station and said in an elevated voice to Nurse Aide #2 she was going to get her feeder, Resident #80. The nurse aide was observed to continue down the hall towards the nursing station and say again she was going to get her feeder. During an interview on 11/18/19 at 12:41 PM, Nurse Aide #1 stated resident who needed help with meals were feeders. She concluded she did not know any other way to describe residents who needed assistance.	F 550	applicable rules and provisions of quality of care of residents. The plan of correction is submitted as written allegation of compliance. Roanoke River Nursing and Rehabilitation Centers response to this Statement of Deficiencies does not denote agreement with Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceedings. F550 An in-service was initiated on 12/12/2019 with all staff, to include Nursing Assistant #1 by the Staff Facilitator in regards to: never use the word feeder when speaking about any resident, to include Resident # 80. All staff were instructed to use the phrase requires assistance with feeding. On 11/19/2019 resident # 65□s tray card was corrected by the Dietary Manager to ensure that tray will be delivered to the locked unit for lunch and supper meal when all other trays arrive to the locked unit. On 12/13/2019 a 100% education was initiated by the Social Worker (SW) with alert and oriented residents utilizing the facility census to include resident # 80 in regards to resident rights. To be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 550	Continued From page 3 During an interview on 11/18/19 at 12:47 PM Nurse Aide #2 stated that staff called residents who needed assistance with meals feeders. During an interview on 11/19/19 at 8:44 AM Resident #80 stated he had heard them refer to him as a feeder. He further stated the use of that term to describe him made him feel very uncomfortable. He continued to say this was because he was used to doing everything for himself before his accident and when staff used the term feeder, everyone could hear it which made him ashamed. During an interview on 11/20/19 at 8:49 AM the Director of Nursing stated staff should not use the term feeders to describe residents who require assistance with meals. She concluded staff were educated about this, but she would begin reeducation. During an interview on 11/21/19 at 8:34 AM the Administrator stated staff should not use the term feeder to refer to residents who needed assistance with meals. 2. Resident #65 was admitted to the facility on 10/9/19 with diagnoses that included hypertension and diabetes. Resident #65's admission minimum data set assessment dated 10/15/19 revealed he was severely cognitively impaired. He was assessed to be independent with eating. During an observation on 11/18/19 at 12:30 PM Resident #65 was observed eating his lunch in the dining room on the locked unit. Other residents were observed sitting at the same table as Resident #65. The remaining residents on the	F 550	completed by 12/16/2019. A 100% in-service for all staff, to include NA # 1 was initiated on 12/12/2019 by the Staff Facilitator in regards to resident□s rights and treating residents with dignity and respect to include not calling residents who require assistance with feeding a feeder and providing meal trays in the dining room to residents by table. In-service will be completed by 1/6/2020. All newly hired staff will be in-serviced by the Staff Facilitator during orientation resident□s rights and treating residents with dignity and respect to include not calling residents who require assistance with feeding a feeder and providing meal trays in the dining room to residents by table. 10% of all staff to include NA # 1 will be monitored during meal times utilizing the Resident Rights Audit Tool by the Staff Facilitator and Unit Managers for resident rights to include not using the word feeders and providing meal trays in dining room to residents by table weekly x 8 weeks then monthly x 1 month. Any concerns during the audits will be addressed immediately by Staff Facilitator and Unit Managers. The Director of Nursing (DON) will review and initial the Resident Rights Audit Tool for completion and to ensure all areas of concern were addressed weekly x 8 weeks then monthly x 1 month. The DON will forward the results of the Resident Rights Audit Tool to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 550	Continued From page 4 locked unit received their lunch trays at 12:45 PM. An interview was conducted with Nurse Aide #12 on 11/18/19 at 1:52 PM who stated Resident #65 was a resident of the facility but did not reside on the locked unit. She reported he spends the day in the locked unit because he was hiding from staff members. Nurse Aide #12 continued that Resident #65's tray was brought to the unit when trays were passed on his unit. During an observation on 11/19/19 at 12:26 PM a lunch tray was observed being given to Resident #65 and he immediately began eating. Other residents were observed sitting at the table with Resident #65 while they were waiting for their trays. Other lunch trays were observed being delivered to the unit at 12:45 PM. An interview was conducted with Nurse Aide #13 on 11/19/19 at 2:48 PM. She reported Resident #65 wandered so he spent his days in the locked unit. Nurse Aide #13 further stated his lunch was delivered to the locked unit when the trays on his hall were delivered. During an interview with Nurse #7 on 11/19/19 at 2:51 PM she stated Resident #65's tray was delivered when his tray comes out on his hall. An interview was conducted with the Dietary Manager on 11/19/19 at 3:05 PM who stated Resident #65 shares a room on the front hall. She stated he spends most of his day on the locked unit. The Dietary Manager stated the kitchen had been sending his tray down to the unit when his tray arrived at his room. She reported that she would ensure his tray was sent with the other trays to the locked unit.	F 550	Executive Quality Assurance Committee monthly x 3 months. The Executive Quality Assurance Committee will meet monthly x 3 months and review the Resident Rights Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 550	Continued From page 5 An interview was conducted with the Administrator on 11/19/19 at 3:12 PM who stated staff should have coordinated and communicated to accommodate Resident #65 receiving his meals at the same time as the other residents on the unit.	F 550		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense.	F 576		12/19/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 576	Continued From page 6 §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to deliver mail to residents on Saturdays. This had the potential to affect all residents who resided in the facility. The findings included: An interview with nine members of the Resident Council on 11/20/19 at 2:10 PM revealed residents did not receive mail at the facility on Saturdays. The residents indicated mail that would have been delivered to them on Saturday was delivered on Monday morning. Residents further indicated they had not experienced any problems because of this and this was the way things had always been. On 11/20/19 at 2:18 PM an interview with the Activities Director indicated the facility did not receive resident mail on Saturdays. She stated the facility had the Saturday mail held at the Post Office and it was delivered to the facility on Monday morning. She went on to say this was because there were no Administrative staff present at the facility to receive the mail on Saturday and the facility did not want anything to get lost. The Activities Director further stated this	F 576	F 576 On 11/23/2019 Saturday mail began delivery to residents. On 12/13/2019 a 100% education was initiated by the Social Worker (SW) with alert and oriented residents utilizing the facility census in regards to resident rights, to include receiving mail on Saturdays. To be completed by 12/16/2019. On 12/12/2019 an in-service was initiated by the Facility Consultant with the Administrator, Managers on Duty (MOD), Director of Nursing (DON) and Weekend Supervisor in regards to resident rights to include receiving mail on Saturdays and the procedure for delivery of mail on Saturday. In-service to be completed on 12/17/2019. All MOD□s or Weekend Supervisors will be interviewed by the Administrator weekly x 8 weeks and monthly x 1 month to ensure mail delivery occurred on Saturday and that residents are receiving	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 576	Continued From page 7 was not a resident council decision and she had not requested for mail not to be delivered to the facility on Saturdays. She stated she did not know who requested the Post Office not to deliver mail to the facility on Saturdays. On 11/20/19 at 2:49 PM an interview with the Administrator indicated she was not aware the facility did not receive resident mail on Saturdays. On 11/20/19 at 2:53 PM an interview with the Receptionist indicated the facility did not receive resident mail on Saturdays because sometimes the mail contained checks and there was no one scheduled to work in the front office on Saturday to receive the mail. On 11/20/19 at 3:56 PM the Administrator indicated she contacted the Post Office. She stated the Post Office informed her the Saturday hold on mail delivery to the facility had been in place since 2016. She further indicated the Post Office was not able to tell her who had placed the hold on the mail. The Administrator further stated the hold on the mail was placed before she started working in the facility. She stated on 11/20/19 she instructed the Post Office to remove the hold and residents would now receive their mail on Saturdays.	F 576	mail utilizing a Mail Delivery Tool. The Administrator will address any identified areas of concern during the audit. The Administrator will review and initial the Mail Delivery tool weekly x 8 weeks and monthly x 1 month to ensure completion and that all areas of concerns were addressed. The Administrator will forward the results of the Mail Delivery tool to the Executive QA Committee monthly x 3 months. The Executive QA committee will meet monthly x 3months and review the Mail Delivery tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 8 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, staff, Nurse Practitioner, responsible party and police interviews, and record review the facility failed to prevent staff to resident abuse for 1 of 1 residents. Resident #7 was struck by a nurse aide four or five times with a closed fist during care. This physical abuse resulted in Resident #7 experiencing bruising to his left arm. The resident had an x-ray and was found to have no fractures. Immediate Jeopardy began on 11/19/19 when Resident #7 was receiving incontinent care from Nurse Aide (NA) #3 and NA #3 struck Resident #7 four or five times with a closed fist. Immediate jeopardy was removed on 11/21/19 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Findings included: Resident #7 was admitted to the facility on 3/13/18. His active diagnoses included: depression, bipolar disorder and schizophrenia.	F 600	F 600 On 11/20/2019 a head to toe assessment was completed by the Treatment nurse on resident # 7 related to allegation of abuse, bilateral bruising noted to lower arms. On 11/20/19, a 100 % Resident Questionnaires were completed by the Social Worker with all alert and oriented residents in regards to: Do you know what abuse means? Are there any instances that you felt you were abused in any way? Do you know of any residents that have been abused in any way? Do you know who to report abuse to? Do you feel safe here? There were no other allegations of abuse verbalized. On 11/20/2019, 100% skin checks were initiated on all residents unable to report for signs/symptoms of abuse utilizing a resident census by the Unit Managers and Assistant Director of Nursing (ADON). No identified concerns noted. The skin checks were completed on 11/21/19. On 11/20/2019, Abuse Quizzes were initiated by the Facility Consultant, Administrator, and Director of Nursing (DON) with 100% of all staff to include nurses, nursing assistants, medication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 9 Resident #7's quarterly minimum data set assessment dated 11/2/19 revealed he was assessed as severely cognitively impaired. He was assessed to have adequate hearing, clear speech and was able to make himself understood by others. He was assessed to have no behaviors. He required extensive assistance with bed mobility, dressing and personal hygiene. He was totally dependent on staff for toilet use. Resident #7 was assessed to be incontinent of bowel and bladder. Resident #7's care plan dated 9/17/19 revealed he was care planned for ineffective coping with Agitation/Combativeness. The interventions included for Resident #7 to receive behavior management and psychiatric consults, give medication as prescribed by the physician, give resident item or task to distract, and pharmacy review of medications monthly and/or as needed. He was also care planned for resistance to treatment and care related to cognitive impairment. Resident #7 refused activities of daily living care and medications. The interventions included to allow for flexibility in activities of daily living routine to accommodate resident's mood, document care being resisted per facility protocol and notify physician of patterns in behavior, and if resident refused care, re-attempt at another time. Resident #7's November 2019 physician's orders revealed the resident was not on any anticoagulant medications. During an interview on 11/21/19 at 1:37 PM Resident #7's family member stated Resident #7 had delusions and thought people were out to get him and on 11/20/19 Resident #7 was making	F 600	aides, dietary staff, housekeeping staff, therapy staff, Administrator, Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Activities Assistant, Medical Records, Central Supply Clerk, Maintenance Director, Maintenance Assistant, Social Worker (SW), and Ward Clerk with questions in regards to (1) who should you report abuse to? (2) When should you report abuse? (3) Give 2 examples of abuse. (4) What is the first thing you do if you see or hear a resident being abused from a staff member, visitor or another resident? (5) Who is the abuse coordinator? (5) If a resident becomes combative or resist care what should you do? Any staff member unable to answer any questions accurately on the quiz will be immediately re-trained and tested again by the DON, Administrator and/ or the Staff Facilitator. Staff who are unable to correctly answer the questions on the quiz after two attempts will be removed from working with residents until they are able to validate knowledge. The abuse quizzes will be completed on 1/6/2020. All newly hired staff will complete an abuse quiz with the Staff Facilitator during orientation. On 11/21/19 a questionnaire was initiated by the Staff Facilitator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 10 delusional statements. The family member stated on 11/20/19 he showed the Facility Nurse Consultant bruises on Resident #7's arm. The family member stated at this point Resident #7 told the Facility Nurse Consultant he had been hit. Facility Nurse Consultant then brought the administrator to the resident's room and Resident #7 then told the Administrator he thought he was hit by Nurse Aide #3 but could not remember what time or the date. The Administrator informed them she would contact the police. The family member specified the police detective arrived and Resident #7 told him a female staff member upset him, and said "if you hit me, I'll hit you back twice as hard." The family member stated Resident #7 told the police detective he hit the staff member and in response the staff member hit him four times. The family member said the police detective told him on 11/21/19 Nurse Aide #3 quit last night and the reason she hit Resident #7 was because he called her a "b ...." During an interview on 11/22/19 at 7:45 AM the Facility Nurse Consultant stated on 11/20/19 around 10:00 AM the family member of Resident #7 spoke to her about some concerns he had with the facility, and as they were talking Resident #7 suddenly stated "and that girl grabbed my arm and hit me." The Facility Nurse Consultant then asked him to repeat what he said, and he stated the same thing. The Facility Nurse Consultant left the room and brought the Administrator to Resident #7's room. She asked Resident #7 to please tell the Administrator what he just told her. Resident #7 then said an aide told him "if you hit me, I ' ll hit you." Resident #7 indicated the nurse aide hit him with a fist four times on his left arm. Resident #7 stated about the third time the nurse aide hit him, he hit her back. Resident #7 stated	F 600	Director, Activities Assistant, Medical Records, Central Supply Clerk, Maintenance Director, Maintenance Assistant, Social Worker (SW), and Ward Clerk with question in regard to: Do you know of any staff member that has abused a resident that has not been reported and addressed? The questionnaires will be completed on 1/6/2020. On 11/21/19, a staff scenario was initiated by the staff facilitator with all nurses and nursing assistants regarding dealing with combative residents and prevention of abuse. The purpose of the scenario is to validate staff knowledge and understanding of what to do when a resident is being combative during care. Any staff member unable to answer any question accurately on the scenario will be immediately re-trained and tested again by the Staff Facilitator. Staff who are unable to correctly answer the question on the scenario after two attempts will be removed from working with residents until they are able to validate knowledge. The scenarios will be completed on 1/6/2020. All newly hired nurses and/or nursing assistants will complete a dealing with combative resident scenario with the Staff facilitator during orientation. On 11/21/2019, the Administrator called the Ombudsman to schedule an in-service in regards to dealing with combative residents and resident abuse. A message was left for the Ombudsman on 11/21/19. The Administrator followed up with the Ombudsman on 11/26/2019 and the Ombudsman stated she will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 11 Nurse Aide #3 was the NA that hit him. The Facility Nurse Consultant stated she and the administrator then left the resident's room, called the police, initiated the 24-hour report to the state and then began their investigation. During an interview on 11/21/19 at 3:54 PM the Administrator stated about 10:00 AM on 11/20/19 she was alerted by the Facility Nurse Consultant that she was needed in Resident #7's room. The administrator stated Resident #7 informed her that Nurse Aide #3 came in his room, held his arm and hit him four times on his left arm with her fist. He then indicated there was bruising along his entire left forearm. Resident #7 said, he was being belligerent with Nurse Aide #3 and the nurse aide said to him "you hit me and I'm going to hit you back." The Administrator stated the facility initiated the 24-hour report, notified the police and began their investigation. The administrator stated Nurse Aide #3 called her at around 3:45 PM on 11/20/19. Nurse Aide #3 first stated to the administrator at around 2:00 PM to 3:00 PM on 11/19/19 she was going to change Resident #7 and when she started with the care, Resident #7 became aggressive. Nurse Aide #3 stated Resident #7 called her a "b ...." and went on to explain the resident required incontinent care. So, she proceeded to get things ready to provide incontinent care for him. Nurse Aide #3 said she put the head of the resident's bed down and Resident #7 started to swing at her. She told Resident #7 don't do that and said, "the resident jumped at me like he wanted to hit me." The resident hit Nurse Aide #3 on her left arm and the nurse aide said she proceeded to turn the resident on his left side where she cleaned his backside and rolled the linens which were soiled under the resident to change them. Nurse Aide #3	F 600	provide the Administrator with a date for the in-services. The Administrator called the Ombudsman back on 12/3/2019 and 12/4/2019 and left messages for the Ombudsman. The Ombudsman called back on 12/5/2019 and the in-service will be held December 20th and the 27th. On 12/12/2019, facility made contact with a Nurse Practioner (NP) with a specialty in Dementia care and training. NP will be in facility on 12/18/2019 and 12/19/2019 to complete Dementia training with staff. On 11/20/2019 an in-service was initiated by the Facility Nurse consultant and Staff facilitator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Activities Assistant, Medical Records, Central Supply Clerk, Maintenance Director, Maintenance Assistant, Social Worker (SW), and Ward Clerk regarding dealing with combative residents, abuse, and dementia training. In-services will completed by 1/6/2020. All newly hired staff will be in-serviced during orientation by the Staff Facilitator in regards to dealing with combative residents, abuse, and dementia training 10% of alert and oriented residents will be interviewed by the SW weekly x 8 weeks then monthly x 1 month utilizing a Resident Abuse Questionaries□ in regards to resident□s understanding of abuse and if abuse has occurred to the resident. The Administrator will review and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 12 stated she then rolled him to his right side where the resident again began swinging at her. She finished cleaning the resident and replaced clean linens on the bed, raised the head of the bed and left the room. The nurse aide stated she went and told Nurse #1 that Resident #7 had behaviors. Nurse Aide #3 then stated that either Nurse Aide #4 or the Wound Care Nurse was in the hallway and heard the resident call her a bitch. Nurse Aide #3 reported no issues or behaviors with morning care on 11/19/19. At that time Nurse Aide #3 denied having any other facts about the incident. After prompting by both the Regional Vice President and Administrator, Nurse Aide #3 said there was more to the story. She then stated the resident was calling her "all kinds of b ....es." While she was changing him, he did jump at her like he was going to hit her. Resident #7 seemed more out of it and started hitting her. She stated she then told Resident #7, "If you hit me again, I'm gonna hit you back." The resident continued to strike Nurse Aide #3 in the chest area. Nurse Aide #3 then stated, "I hit him a few times. Twice on the arm, on his side, and then on his thigh." She stated she did not strike him hard and then she reported to Nurse #1 about the behaviors but did not report that she had struck the resident. The Administrator stated at that point Nurse Aide #3's employment was obviously terminated and a full plan of correction was immediately initiated. During an interview on 11/21/19 at 1:56 PM Resident #7 stated a nurse aide made him angry but could not remember why. He stated he then made a fist with his right hand and the nurse aide told him, "hit me and I'll hit you again harder." Resident #7 further stated he then hit the nurse aide and the nurse aide hit him back on the arm.	F 600	initial Resident Abuse Questionnaires weekly for 8 weeks then monthly for 1 month to assure all areas of concern have been addressed. 10 % of all staff to include licensed nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Director of Nursing (DON), Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Activities Assistant, Quality Assurance Nurse (QA), Medical Records, Minimum Data Set Nurses (MDS), treatment nurses, Staff Facilitator, Central Supply Clerk, Maintenance Director, Maintenance Assistant, SocialWorker (SW), Ward Clerk and Assistant Director of Nursing (ADON) will complete an Abuse Quiz to ensure that staff are knowledgeable on the policy of abuse and dealing with combative residents weekly for 8 weeks and monthly for 1 month. Any staff member unable to answer any questions accurately on the quiz will be immediately re-trained and tested again by the DON, Administrator and/ or the Staff Facilitator. Staff who are unable to correctly answer the questions on the quiz after two attempts will be removed from working with residents until they are able to validate knowledge. The Administrator will review and sign the abuse quizzes for completion and that any areas of concern are addressed appropriately. 10 % of all nurses, medication aides and nursing assistants will be monitored during care by the Staff Facilitator, ADON and Unit Managers utilizing a Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 13 Review of a written statement dated 11/20/19 revealed the following statement was obtained from Nurse Aide #3 by the Administrator. Nurse Aide #3 called the facility as per the Administrator's request at about 3:34 PM on 11/20/19 to discuss the physical abuse allegation that was made against her. The Administrator asked if she had any issues recently with Resident #7. Nurse Aide #3 explained Resident #7 yelled out a lot and he always thought someone was going to cut something off him such as his legs or arms. The nurse aide went on to explain Resident #7 had visual hallucinations. Nurse Aide #3 then stated on 11/19/19 Resident #7 was aggressive and struck her in her chest area. The nurse aide told Resident #7 not to do that and Resident #7 apologized. Nurse Aide #3 stated she worked with Resident #7 on both 11/16/19 and 11/17/19 on 7 AM to 3 PM shift. Nurse Aide #3 stated Resident #7 did not have any behaviors on those shifts. The Administrator asked Nurse Aide #3 if Resident #7 had ever made a statement to her about being struck or hit by someone to which the nurse aide responded "no." Nurse Aide #3 was then asked to explain the combative episode on 11/19/19 in greater detail. The nurse aide stated around 2 PM or 3 PM she went to change Resident #7 and he became aggressive and called her a "b ...." She put his bed down and Resident #7 started to swing at her. Nurse Aide #3 told Resident #7 not to do that. The resident jumped at her like he wanted to hit her. He hit her on the left arm, and she turned him on his left side and cleaned his back side. Nurse Aide #3 then rolled him to his right side and Resident #7 again began to swing at her. She finished care and placed the bed back in the position it had been prior to care and exited the room. She informed Nurse #1 of his behaviors.	F 600	Care Audit to ensure that no signs/ symptoms of abuse are noted and that staff are performing care correctly weekly for 8 weeks and monthly for 1 month. Any areas of concern will be immediately addressed by the DON, Administrator or Staff Facilitator. The DON will review and sign the Resident Care Audits for completion and that any areas of concern are addressed appropriately. 10% of all nurses and nursing assistants will complete a dealing with combative residents/prevention of abuse scenario by the Staff Facilitator or Unit Managers weekly for 8 weeks and monthly for 1 month. The purpose of the scenarios are to ensure that staff maintains knowledge and understanding of what to do when residents are combative during care. Any staff member unable to answer any questions accurately on the scenario will be immediately re-trained and retested by the Staff Facilitator. Staff who are unable to correctly answer the scenario after two attempts will be removed from working with residents until they are able to validate knowledge and understanding. The DON will review and initial the combative resident scenarios for completion and to ensure that all areas of concern have been addressed. The Administrator will forward the results of the Resident Abuse Questionnaires, Staff Abuse Quizzes, Resident Care Audits Tool and Staff Combative Resident Scenario□s to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 14 She stated Nurse Aide #4 or the Wound Care Nurse were in the hallway and heard the resident call her a bitch. Nurse Aide #3 was then asked if there was anything else that the Administrator needed to be aware of and Nurse Aide #3 denied having any other information. The Regional Vice President then took over the line of questioning and told Nurse Aide #3 the Sheriff's Department had explained to the facility that Nurse Aide #3 had pertinent information on Resident #7. Then Nurse Aide #3, after prompting by the Administrator and Regional Vice President, stated there was more to the story. She then stated Resident #7 was calling her, "all kinds of bitches." While she changed him, he jumped at her like he was going to hit her and he seemed more out of it. Resident #7 began hitting her and she told him, "if you hit me again, I'm gonna hit you back." Resident #7 continued to strike Nurse Aide #3 in the chest area. Nurse Aide #3 then told them she hit Resident #7 a few times, twice on the arm, on his side and then on his thigh. She explained that she did not hit him hard. The nurse aide then concluded she told Nurse #1 about the behaviors but did not report that she had struck the resident. During a phone interview on 11/21/19 at 4:18 PM Nurse Aide #3 stated she went in Resident #7's room on 11/19/19 to provide incontinent care between 2:00 PM and 3:00 PM. The aide stated Resident #7 was combative. Resident #7 was soiled and had a bowel movement. Nurse Aide #3 stated she prepped everything she needed for incontinent care and entered his room. Resident #7 swung at her as she was laying him back and she told Resident #7 not to do that. She stated she proceeded to change him and as she was taking his brief off. Resident #7 was still swinging at her and she continued to tell him not to do that.	F 600	Resident Abuse Questionnaires, Staff Abuse Quizzes, Resident Care Audits Tool and Staff Scenario□s to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 15	F 600		

She rotated Resident #7 to his left side, cleaned his backside and put a new brief under him. She stated she then rotated him towards her and he again began swinging at her. Nurse Aide #3 told him it was not nice to swing at people. She stated she then "popped" him on the upper right side of his left arm around the shoulder area. She stated she hit Resident #7 four or five times. She stated she hit him for every time he hit her. Nurse Aide #3 continued to state they went back and forth a few times and then she turned him on his back to get his brief on. When asked what she meant by she "popped" the resident, Nurse Aide #3 stated she struck Resident #7 with a closed fist but not very hard. At this point Resident #7 was calling her a "b ...." Nurse Aide #3 stated she raised the head of his bed up and left the room. She went to Nurse #1 and informed her Resident #7 was having behaviors. She stated she did not inform Nurse #1 that she hit Resident #7. She stated after that it was time to go home as it was shift change. The nurse aide concluded she did not inform any staff she hit Resident #7 and did not return to work.

During an interview on 11/21/19 at 3:16 PM the police detective with the local Police Department stated the police had probable cause through a confession from Nurse Aide #3 that she assaulted Resident #7. The nurse aide admitted to hitting Resident #7 with a closed fist five times which lead the detective to pursue a felony warrant against NA #3 for "abusing a patient with injury."

A review of a witness statement dated 11/21/19 revealed Nurse #1 stated on 11/19/19 at about 2:50 PM Nurse Aide #3 came to her at the nursing station. Nurse Aide #3 informed her Resident #7 was acting up during care and he did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 16	F 600		

not want her to do his care. Nurse #1 told Nurse Aide #3 she would go to his room and the nurse aide informed her there was no need because she already finished care. Nurse #1 told Nurse Aide #3 from then on to come get her when residents were acting up or refusing care. Nurse Aide #3 stated okay, and Nurse #1 concluded she did not notice any abnormal bruising on Resident #7 and he never reported any abuse on anyone treating him badly. She stated the Director of Nursing had already documented the bruising before she came on shift on 11/21/19.

During an interview on 11/21/19 at 6:13 PM Nurse #1 stated on 11/19/19 at 2:50 PM Nurse Aide #3 came to her at the nursing station and stated Resident #7 had been combative during care. She further stated she then offered to go down to the room and assist with his care. The nurse aide stated she had already completed the care. The nurse then educated the nurse aide the next time he was combative to come and get her for assistance. She further stated the nurse aide did not inform her she had struck Resident #7. The nurse aide stated okay and went home. She further stated she did not notice any complaints of pain, bruising, or anything to Resident #7's left side. Nurse #1 stated she had no reason to look for his bruising and did not do skin checks unless something was wrong. She further stated on 11/20/19 her nurse aide did not report any bruising to Resident #7's left side.

During an interview on 11/22/19 at 2:11 PM Medication Aide #1 stated she worked with Resident #7 on second shift on 11/19/19. She stated Nurse #1 did not tell her anything specific about Resident #7 when she came on duty on 11/19/19. She further stated she did not notice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 17	F 600		

any unusual or new bruising to Resident #7. She stated the only behaviors she noted that shift with Resident #7 was around 5:00 PM she heard him calling the nurse aide a "b ....".

During an interview on 11/22/19 at 11:41 AM Nurse #2 stated she was Resident #7's nurse on 11:00 PM to 7:00 AM shift the night of 11/19/19. She stated Nurse #3 did not report anything unusual about Resident #7 during change of shift report.

During observation on 11/21/19 at 6:21 PM Resident #7 was assessed with the Director of Nursing. No bruises were noted on his left upper arm or shoulder, no bruises on left chest or abdomen area, no bruises were observed on his left thigh. Resident #7 was noted to have a large bruise on his left lower arm and several smaller bruises on his left lower arm around the elbow area. Some bruising was noted on his left hand. The Director of Nursing had measured bruising and documented the bruise to his left lower arm to be approximately 12 centimeters long by 7 centimeters wide

A skin assessment and measurements performed by the Director of Nursing on 11/21/19 revealed Resident #7's left upper forearm had a large bruise 12 centimeters long and 7 centimeters wide. His left upper wrist also had a bruise which measured 3 centimeters long and 3.5 centimeters wide. A small u-shaped scab was documented on the skin where the large bruise was. It was less than 0.3 centimeters in size.

The radiology results report for Resident #7 revealed on 11/21/19 an x-ray had been taken of Resident #7's left arm. The findings were elbow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 18	F 600		

arthritis, spurring of the elbow and no fractures or displacement.

During another interview on 11/22/19 at 11:17 AM Facility Nurse Consultant #1 stated she informed the Psychiatric Mental Health Nurse Practitioner there were allegations of abuse for Resident #7. She stated she intended for Resident #7 to tell her about the incident. She stated she would have liked to have told her specifically that Resident #7 had been struck by Nurse Aide #3, but the Psychiatric Mental Health Nurse Practitioner had spoken to her on the hallway. She concluded she would ask her to reevaluate the resident.

During an interview on 11/22/19 at 11:54 AM the Psychiatric Mental Health Nurse Practitioner stated she reevaluated Resident #7 on 11/22/19. She stated he was somewhat irritable and she introduced herself. Resident #7 stated he did not trust her because she lied to his family member. She asked what she said and Resident #7 stated "you know what you said." She asked him again and he stated everyone would all evaporate soon. She stated she asked him to describe what happened when he got hit and Resident #7 stated he could not remember. Resident #7 told her she had all the information. She stated Resident #7 presented to her the same as before and she did not feel he had suffered any psychosocial trauma at that time. She further stated he could be blocking his experience and there was potential for trauma related to the incident.

The Administrator was notified of the immediate jeopardy on 11/21/19 at 7:00 PM. On 11/22/18 at 10:43 AM the facility provided the following credible allegation of immediate jeopardy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 19	F 600		

removal.

"F 600-Abuse

· Recipients who have suffered or are likely to suffer, a serious adverse outcome as a result of the non-compliance

Resident # 7 is alert and oriented to self with a diagnosis of Schizophrenia, Major Depressive Disorder, Bipolar Disorder, and Dementia without behavioral disturbance. On 11/20/2019 at approximately 10:00 am, resident # 7 reported to the Facility Nurse Consultant that a Nursing Assistant (NA) # 3 held resident's arm down and punched residents arm four times with a closed fist. On 11/20/2019 at approximately 10:02 am the Facility Nurse Consultant made the Administrator aware of resident # 7's report of abuse. On 11/20/2019 at approximately 10:05 am, the Administrator and the Facility Nurse Consultant re-interviewed resident # 7 regarding the allegation of abuse. On 11/20/2019 the hall nurse completed a head to toe assessment on resident # 7 with no signs and symptoms of abuse observed. On 11/20/2019 at approximately 11:10 am the Administrator notified the police department of resident # 7's allegation of abuse. On 11/20/19 the Resident Representative (RR) of resident # 7 was in resident # 7's room when resident # 7 reported the allegation of abuse. On 11/20/2019 at approximately 11:30 am, the police department arrived onsite to investigate the allegation of abuse. On 11/20/19 the physician was notified of the allegation of abuse. On 11/20/19 a thorough investigation was initiated by the Administrator and Director of Nursing related to the allegation of abuse reported by resident #7. On 11/20/19 the Administrator completed and faxed the initial allegation report to the Health Care Personnel Investigations. Resident # 7 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 20	F 600		

reassessed by the Director of Nursing on 11/21/19 with a bruise observed to resident's left arm. On 11/21/19, the physician was notified of the bruise by the Director of nursing with an order received to obtain an x-ray. The x-ray results were negative for an injury. After 11/19/2019 NA # 3 never returned back to work. Psych services is scheduled to be at facility on 11/22/2019 to assess resident # 7 for psychosocial follow-up. Resident # 7 has no negative affect noted.
On 11/20/19, a 100 % Resident Questionnaires was completed by the Social Worker with all alert and oriented residents in regards to: Do you know what abuse means? Are there any instances that you felt you were abused in any way? Do you know of any residents that have been abused in any way? Do you know who to report abuse to? Do you feel safe here? There were no other allegations of abuse verbalized.
On 11/20/2019, 100% skin checks were initiated on all residents to include resident # 7, who are unable to report signs/symptoms of abuse utilizing a resident census by the Unit Managers, Hall nurses and Assistant Director of Nursing. The skin checks will be completed by 11/21/19.

· Actions taken to alter the process or system failure to prevent a serious adverse outcome for occurring or recurring

On 11/20/2019, Abuse Quizzes were initiated by the Facility Consultant, Administrator, and DON with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Activities Assistant, Medical Records, Central Supply Clerk, Maintenance Director,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 21	F 600		

Maintenance Assistant, Social Worker (SW), and Ward Clerk with questions in regards to (1) who should you report abuse to? (2) When should you report abuse? (3) Give 2 examples of abuse. (4) What is the first thing you do if you see or hear a resident being abused from a staff member, visitor or another resident? (5) Who is the abuse coordinator? (5) If a resident becomes combative or resist care what should you do? The abuse quizzes will be completed by 11/21/19. After 11/21/2019 any remaining staff that has not worked and not received the quizzes will receive it prior to starting the next scheduled shift.

On 11/21/2019, the Administrator called the Ombudsman to schedule an in-service in regards to dealing with combative residents and resident abuse. A message was left for the Ombudsman on 11/21/19. The in-service will be posted once scheduled for mandatory attendance by all staff.

On 11/21/19 a questionnaire was initiated by the staff facilitator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Activities Assistant, Medical Records, Central Supply Clerk, Maintenance Director, Maintenance Assistant, Social Worker (SW), and Ward Clerk with question in regard to: Do you know of any staff member that has abused a resident that has not been reported and addressed? The questionnaires will be completed by 11/21/19. After 11/21/2019 any remaining staff that has not worked and not received the questionnaire will receive it prior to starting the next scheduled shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 22	F 600		

On 11/21/19, a staff scenario was initiated by the staff facilitator with all nurses and nursing assistants regarding dealing with combative residents and prevention of abuse. The purpose of the scenario is to validate staff knowledge and understanding of what to do when a resident is being combative during care. The scenarios will be completed by 11/21/19. After 11/21/2019 any remaining staff that has not worked and not received the scenario will receive it prior to starting the next scheduled shift.

On 11/20/2019 an in-service was initiated by the Facility Nurse consultant and staff facilitator with 100% of all staff to include nurses, nursing assistants, medication aides, dietary staff, housekeeping staff, therapy staff, Administrator, Administrative assistant, Admissions Coordinator, Accounts Receivable, Account Payable, Activities Director, Activities Assistant, Medical Records, Central Supply Clerk, Maintenance Director, Maintenance Assistant, Social Worker (SW), and Ward Clerk regarding dealing with combative residents, abuse, and dementia training. The in-service included verbal, sexual, mental or physical abuse, neglect or mistreatment of residents to include exploitation, involuntary seclusion, or corporal punishment, and/or misappropriation of residents ' property will not be tolerated. In-services to be completed by 11/21/2019. After 11/21/19, the receptionist will mail the in-services via certified mail to any remaining staff who has not worked and not received the in-service with instructions to review, sign the in-service, and return to the staff facilitator or Director prior to next scheduled work shift.

The Administrator and Director of Nursing were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 600	Continued From page 23 responsible for the implementation of corrective actions to include all 100% audits and in-services. · Date of corrective action completion Immediate Jeopardy Removal date will be 11/21/2019." The credible allegation for Immediate Jeopardy removal was validated on 11/22/19 at 3:09 PM, which removed the Immediate Jeopardy on 11/21/19, as evidenced by staff interviews, in-service record reviews, and observation. The in services included information on caring for combative residents, abuse and neglect policies and procedures, types of abuse, and reporting incidents of abuse.	F 600		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment for the area of wander alarms (Resident #65, Resident #40, Resident #29, Resident #103, and Resident #101) and dialysis (Resident #71) for 7 of 27 assessments reviewed. Findings included: 1. Resident #65 was admitted to the facility on 10/9/19 with diagnoses that included hypertension and diabetes.	F 641	F641-Accuracy of Assessments The Minimum Data Set (MDS) assessment for resident # 71 was modified by the MDS nurse on 11/20/2019 to reflect dialysis. The Minimum Data Set (MDS) assessment for resident # 65, # 40, # 29, # 103 and # 101 was modified by the MDS nurse on 12/3/2019 to reflect the use of wander alarm bracelets. 100% audit of all current resident most current MDS assessment was initiated on 12/16/2019 by the Director of Nursing (DON) utilizing a MDS Accuracy Audit tool	1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 641	Continued From page 24 Resident #65's care plan dated 10/9/19 revealed placement of a wander alarm on Resident #65's right ankle. During an interview with Nurse Aide #2 on 11/21/19 at 10:00 AM she reported Resident #65 had a wander alarm on his right ankle. An observation on 11/21/19 at 10:09 AM revealed a wander alarm on Resident #65's right ankle. Resident #65's MDS assessment dated 10/15/19, an admission assessment, revealed in Section P no use of a wander alarm. During a interview on 11/21/19 at 4:20 PM MDS Nurse #1 stated Resident #65's MDS assessment should have reflected the use of a wander alarm. During an interview with the administrator on 11/22/19 at 2:15 PM she indicated Resident #65's MDS assessment should have accurately reflected the use of a wander alarm. 2. Resident #40 was admitted to the facility on 7/26/17 with diagnoses that included dementia and hyperlipidemia. Resident #40's care plan dated 7/14/19 revealed placement of a wander alarm on Resident #40's right ankle. During an interview with Nurse Aide #9 on 11/21/19 at 10:20 AM he reported Resident #40 had a wander alarm on his right ankle. An observation on 11/21/19 at 10:23 AM revealed a wander alarm on Resident #40's right ankle.	F 641	to ensure all completed MDS□s were accurately coded to reflect dialysis and use of wander alarm bracelets. Any identified areas of concerns were corrected to include modifications by the MDS Nurses during the audit. Audit completed by 1/6/2020 . On 12/12/2019 an in-service was initiated by the Facility Consultant with the MDS Coordinator and MDS Nurse in regards to accurately coding the MDS, to reflect dialysis and use of wander alarm bracelets. In-Service to be completed by 12/16/2019. 10% of completed MDS□s, will be reviewed by the DON to ensure all MDS□s are accurately coded to reflect dialysis and use of wander alarm bracelets utilizing an MDS Accuracy QA Tool weekly for 8 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the DON to include additional training and modifications to assessment as indicated. The Administrator will review and initial the MDS Accuracy QA Tool weekly for 8 weeks and then monthly for 1 month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QA Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the MDS Accuracy QA Tool to determine trends and/or issues that may need further interventions put into place and to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 641	Continued From page 25	F 641		

Resident #40's MDS assessment dated 10/1/19, a quarterly assessment, revealed in Section P no use of a wander alarm.

During a interview on 11/21/19 at 4:20 PM MDS Nurse #1 stated Resident #40's MDS assessment should have reflected the use of a wander alarm.

During an interview with the administrator on 11/22/19 at 2:15 PM she indicated Resident #40's MDS assessment should have accurately reflected the use of a wander alarm.

3. Resident #29 was admitted to the facility on 9/12/07 with diagnoses that included diabetes mellitus and hypothyroidism.

During an interview with Nurse Aide #8 on 11/21/19 at 10:30 AM she reported Resident #29 had a wander alarm on her walker. She further stated Resident #29 will ambulate in her room without the walker but will not come out of her room without the walker.

An observation on 11/21/19 at 10:34 AM revealed a wander alarm on the right upper bar of Resident #29's walker.

Resident #29's MDS assessment dated 9/6/19, a quarterly assessment, revealed in Section P no use of a wander alarm.

During an interview on 11/21/19 at 4:20 PM MDS Nurse #1 stated Resident #29's MDS assessment should have reflected the use of a wander alarm.

During an interview with the administrator on 11/22/19 at 2:15 PM she indicated Resident #29's MDS assessment should have accurately

determine the need for further and/or frequency of monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 641	Continued From page 26	F 641		

reflected the use of a wander alarm.

4. Resident #103 was admitted to the facility on 10/25/19 with diagnoses that included chronic obstructive pulmonary disease.

During an interview with Nurse Aide #8 on 11/21/19 at 10:30 AM she reported Resident #103 had a wander alarm.

An observation on 11/21/19 at 10:40 AM revealed a wander alarm on Resident #103's right ankle.

Resident #103's MDS assessment dated 10/31/19, an admission assessment, revealed in Section P no use of a wander alarm.

During a interview on 11/21/19 at 4:20 PM MDS Nurse #1 stated Resident #103's MDS assessment should have reflected the use of a wander alarm.

During an interview with the administrator on 11/22/19 at 2:15 PM she indicated Resident #103's MDS assessment should have accurately reflected the use of a wander alarm.

5. Resident #101 was admitted to the facility on 7/27/18 with diagnoses that included dementia and hypertension.

Resident #101's care plan dated 8/14/19 revealed placement of a wander alarm on Resident #101.

During an interview with Nurse Aide #8 on 11/21/19 at 10:20 AM she reported Resident #101 had a wander alarm on his right ankle.

An observation on 11/21/19 at 10:45 AM revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 641	Continued From page 27	F 641		

a wander alarm on Resident #101's right ankle.

Resident #101's MDS assessment dated 10/29/19, a quarterly assessment, revealed in Section P no use of a wander alarm.

During an interview on 11/21/19 at 4:20 PM MDS Nurse #1 stated Resident #101's MDS assessment should have reflected the use of a wander alarm.

During an interview with the administrator on 11/22/19 at 2:15 PM she indicated Resident #101's MDS assessment should have accurately reflected the use of a wander alarm.

6. Resident #71 was admitted to the facility on 9/13/19. His active diagnosis included end stage renal disease.

A review of Resident #71's admission nursing note dated 9/13/19 revealed he was documented to receive dialysis three times a week.

A review of Resident #71's nursing notes revealed on 9/14/19 Resident #71 was transported to dialysis.

A review of Resident #71's admission minimum data set assessment dated 9/20/19 revealed in section O0100 question J he was assessed to not receive dialysis.

During an interview on 11/19/19 at 4:11 PM Wound Care Nurse #1 stated Resident #71 had been a dialysis resident his entire stay since 9/13/19. She concluded his first day of dialysis was 9/14/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 641	Continued From page 28 During an interview on 11/19/19 at 1:53 PM Nurse #1 stated she was Resident #71's regular nurse. Resident #71 had been a dialysis resident his entire stay since 9/13/19. She stated his first day of dialysis was 9/14/19. During an interview on 11/19/19 at 3:25 PM MDS Nurse #1 stated Resident #71 had been on dialysis since he arrived in the facility. She concluded the minimum data set assessment dated 9/20/19 was incorrect. During an interview on 11/21/19 at 8:34 AM the Administrator stated the minimum data set assessment dated 9/20/19 should have accurately reflected Resident #71's dialysis status.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon	F 644		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 644	Continued From page 29 a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record review the facility failed to provide individual or group psychotherapy to a resident who had been assessed the Pre-Admission Screening Resident Review (PASARR) agency to require psychotherapy for 1 of 2 residents reviewed for PASARR. (Resident #79) Findings included: Review of Resident #79 ' s PASARR Level II Determination Notification dated 5/9/19 revealed he was assessed to be a PASARR level II resident. The notification indicated Resident #79 was to receive individual/group psychotherapy. Resident #79 was admitted to the facility on 6/3/19. His active diagnosis included anxiety disorder and depression. A review of Resident #79 ' s minimum data set assessment dated 10/17/19 revealed he was assessed to not be receiving Psychological Therapy. A review of Resident #79 ' s care plan dated 10/29/19 revealed he was care planned for his level II PASARR status. The intervention read, "Level II Preadmission Screening and Resident Review (PASRR) Recommendation: no specific recommendations. One year limitation. Level C." A review of Resident #79 ' s chart revealed he had not been seen for psychotherapy during his stay in the facility.	F 644	F644 On 12/16/2019 the Level II Preadmission Screening and Resident Review (PASRR) recommendations were incorporated into the care plan for resident # 79 by the Social Worker. On 11/22/2019 resident #79 was seen Psychiatric NP related to the notification from PASRR Level 2 Letter. On 12/12/2019 a 100% review of all current residents with PASRR level 2 was completed by the Admissions Coordinator utilizing a resident census to ensure that any recommendations noted from the PASRR level 2 letter were followed and incorporated into the care plan as indicated. All identified issues were corrected during the audit by the Social Work during the audit. On 12/13/2019 the Social Worker (SW), Admissions Director and Director of Nursing (DON) were in-serviced by the Administrator on requirements for PASSR level 2 letter recommendations. 10% of residents with PASRR level 2 with recommendations identified and care plans will be monitored by the Admissions Director, to include resident # 79 to ensure the recommendations were followed timely and recommendations incorporated in the care plans utilizing a PASRR audit tool weekly X 8 week□s then monthly X 1 month. Any identified areas of concerns will be corrected during the audit by the SW to include updating the care plan and re-education as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 644	Continued From page 30 During an interview on 11/20/19 at 4:11 PM the Social Worker stated because the PASARR was performed in the hospital the letter did not come to the facility, so she did not know what specialized services Resident #79 needed. She concluded she did not know how to find out what the specialized services he needed. She further stated she did not input the information in the care plan that he did not have any specialized services but that the minimum data set nurse did those care plans at that time. She again concluded he came in June 4th and the PASARR was done on May 9th, so it was done in the hospital and she did not have access to his letter, so she wrote down one year limitation for the level C. During an interview on 11/20/19 at 4:29 PM MDS Nurse #1 stated the Social Worker would have verbally informed her about the PASARR status of Resident #79 and that there were no recommendations. She concluded Resident #79 ' s PASARR had no specific recommendations. During an interview on 11/20/19 at 4:51 PM the Director of Nursing stated a consent must be signed from the physician and family in order to arrange psychotherapy or psychiatry services. She further stated when Resident #79 was first admitted his family would have been signing consents for him because he was unable to. She further stated to her knowledge Resident #79 had not been seen by psychiatric services as the consent had not been signed by the facility physicians' assistant until 11/11/19. She stated the responsible party had signed the consent on 6/11/19. Upon review of the PASARR letter she concluded Resident #79 should have received specialized services. She further stated Resident	F 644	appropriate. The Director of Nursing (DON) will review and initial the PASRR audit tool weekly for 8 weeks then monthly for 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the PASRR Audit tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the PASRR Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 644	Continued From page 31 #79's care plan should have reflected his psychiatric needs. During an interview on 11/21/19 at 7:47 AM Resident #79 stated he had received no psychotherapy in the facility. During an interview on 11/21/19 at 8:34 AM the Administrator stated Resident #79 should have received services that were deemed necessary by the PASARR agency prior to now.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 655	Continued From page 32 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a baseline care plan within 48 hours of admission for 1 of 44 residents (Resident # 103) reviewed for care plans. Finding included: Resident # 103 was admitted to the facility on 10/25/2019 with diagnoses which included chronic obstructive pulmonary disease, depressive disorder, and seizures. An Admission Minimum Data set (MDS) dated 10/31/2019 revealed Resident #103 was severely cognitively impaired and required supervision with bathing. The resident was independent with all other activities of daily living. A review of Resident #103's baseline care plan	F 655	F 655 On 10/28/2019 resident # 103□s care plan was updated by the Minimum Data Set (MDS) Nurse. 100% audit of all residents admitted in the last 30 days was initiated on 12/16/2019 by the MDS Coordinator to ensure that base line care plans were in place. Audit to be completed by 12/18/2019. All identified areas of concerns will be addressed by the Unit Manager during the audit to include updating the care plan. On 12/12/2019 an in-service was initiated by the Facility Consultant with the Social Worker (SW), Dietary Manager, Activity Director, Director of Nursing (DON), Staff Facilitator, Unit Mangers and hall nurses in regards to base line care plans requirements. In-services to be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 655	Continued From page 33 revealed it was dated for 10/28/2019. During an interview with MDS Nurse #1 on 11/21/2019 at 4:30 pm, she revealed the completion of the baseline care plan was in the process of being transferred to the nursing staff. She further stated when the MDS department learned the baseline care plan had not been done, MDS Nurse #2 completed it to reflect Resident #103's needs. MDS Nurse # 1 also stated the baseline care plan should have been done within 48 hours. On 11/22/2019 at 2:30 pm during an interview with the Administrator, she revealed the baseline care plan should have been completed within the appropriate time frame.	F 655	by the Staff Facilitator by 1/6/2020. All newly hired Social Worker (SW), Dietary Manager, Activity Director, DON, Unit Managers or hall nurses will be in-serviced during orientation by the Staff Facilitator in regards to base line care plan requirements. 10 % of all new admits will be reviewed by the MDS Coordinator for timely completion of the base line care plans weekly X 8 weeks and monthly X 1 month utilizing the Base Line Care Plan Audit Tool. The DON will immediately retrain the Social Worker (SW), Dietary Manager, Activity Director, Staff Facilitator, Unit Managers or hall nurses during the audit for any identified areas of concerns. The Administrator will review and initial the Base Line Care Plan Audit Tool weekly X 8 weeks and monthly X 1 month to ensure completion and that all areas of concerns have been addressed. The Administrator will forward the results of the Base Line Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA committee will meet monthly x 3months and review the Base Line Care Plan Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 657	Continued From page 34 (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 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to review and/or revise the care plan to reflect the individual care needs for 2 of 44 residents reviewed for care plan (Residents #97 & #79). Findings Included: 1. Resident #97 was admitted to the facility on 10/12/18 with reentry on 7/01/19 with diagnoses which included dysphagia and cerebrovascular accident (CVA).	F 657	F657 On 11/20/2019 resident # 97□s care plan was revised by the Minimum Date Set (MDS) Coordinator to reflect the correct diet consistency. On 12/16/2019 resident # 79□s care plan was revised to incorporate the PASRR level 2 recommendations by the Social Worker (SW). On 12/17/2019 a 100% audit was initiated of all current residents care plans, to include # 97 and # 79 by the Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 657	Continued From page 35 A physician's order dated 7/01/19 indicated Resident #97 should receive a pureed diet. A review of the quarterly Minimum Data Set (MDS) dated 7/27/19 indicated Resident #97 had moderately impaired cognition and was coded for a mechanically altered diet. A review of the significant change in status MDS dated 10/24/19 indicated Resident #97 was coded for a mechanically altered diet. A review of the care plan for Resident #97 with a revised date of 10/23/19 revealed a focus on the state of nourishment with interventions which included mechanical soft diet with ground meats. An interview with the Nurse Aide (NA) #11 on 11/19/19 at 3:28 PM indicated Resident #97 ate a pureed diet. An interview with the Registered Dietitian (RD) #1 on 11/19/19 at 11:17 AM revealed Resident #97 ate a pureed diet as recommended by Speech Therapy. An interview with the Speech Therapist (ST) #1 on 11/20/19 at 2:35 PM revealed Resident #97 ate a pureed diet due to moderate dysphagia (difficulty swallowing). An interview with the MDS Coordinator on 11/20/19 at 4:21 PM revealed she was responsible for ensuring the care plan was accurate and she should have revised Resident #97's care plan when his diet order was changed to puree but she had not done so. The MDS Coordinator indicated the nurse or unit manager updated the care plans but it was her	F 657	Nursing (DON) for residents with care plans for residents with PASRR level 2 and dietary needs to ensure the care plan incorporated recommendations from PASRR level 2 and correct diet consistency. Any identified areas of concerns will be corrected by Assistant Director of Nursing during the audit. The audit was completed on 12/23/19. On 12/16/2019 an in-service was initiated by the Facility Nurse Consultant with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers, Staff Facilitator, Dietary Manager, Social Worker, MDS nurses and hall nurses in regards to developing, implementing and revising a comprehensive care plan for recommendations from PASRR level 2 and correct dietary consistency. In-service to be completed 1/6/2020. Any newly hired DON, ADON, Unit Manager, Dietary Manager, SW, MDS Nurse or hall nurse will be educated by the Staff Facilitator during orientation in regards to developing, implementing and revising a comprehensive care plan for recommendations from PASRR level 2 and correct dietary consistency. 10% of residents care plans, to include resident # 97 and # 79, will be audited to ensure the care plans addressed diet consistency and incorporates any recommendations from PASRR level 2 utilizing a Care plan audit tool by the Unit Managers and Staff Facilitator weekly X 8 weeks then monthly X 1 month. Any identified areas of concerns will be corrected by the Staff Facilitator or Unit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 657	Continued From page 36 responsibility to verify the data was correct and she did not know how it had been missed but she would correct it. An interview with the Administrator on 11/21/19 at 9:18 AM indicated she expected MDS to review the care plans to reflect the correct picture of Resident #97 at any given point in time. 2. Resident #79's Preadmission Screening and Resident Review (PASARR) Level II Determination Notification dated 5/9/19 revealed he was assessed to be a PASARR level II resident. The notification indicated Resident #79 was to receive individual/group psychotherapy. Resident #79 was admitted to the facility on 6/3/19. His active diagnosis included anxiety disorder and depression. Resident #79's minimum data set (MDS) assessment dated 10/17/19 revealed he was assessed to not be receiving Psychological Therapy. Resident #79's care plan dated 10/29/19 revealed he was care planned for his level II PASARR status. The intervention read, "Level II Preadmission Screening and Resident Review (PASRR) Recommendation: no specific recommendations. One year limitation. Level C."	F 657	Managers during the audit. The DON will review and initial the Care plan audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Administrator will forward the results of the Care Plan Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the Care Plan Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 657	Continued From page 37 Resident #79's chart revealed he had not been seen for psychotherapy during his stay in the facility. During an interview on 11/20/19 at 4:11 PM the Social Worker stated she did not input the information in the care plan that he did not have any specialized services and MDS Nurse #1 did those care plans at that time. She concluded Resident #79 came to the facility June 4th and the PASARR was done on May 9th so it was done in the hospital and she did not have access to his letter, so she wrote down one year limitation for the level C. During an interview on 11/20/19 at 4:29 PM MDS Nurse #1 stated the Social Worker would have verbally informed her about the PASARR status of Resident #79 and that there were no recommendations. She concluded Resident #79's PASARR had no specific recommendations. During an interview on 11/20/19 at 4:51 PM the Director of Nursing stated Resident #79's care plan should have reflected his psychiatric needs as indicated by the PASARR determination notification letter. During an interview on 11/21/19 at 8:34 AM the Administrator stated Resident #79's care plan should have captured the recommendations provided by the PASARR agency.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who	F 695		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 695	Continued From page 38 needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and Physician interviews the facility failed to provide tracheostomy care according to manufacturer's guidelines by cleaning and reusing a disposable inner tracheostomy cannula for 1 of 1 resident (Resident #67) reviewed for tracheostomy care . Findings included: A review of the facility's policy titled "Tracheostomy" dated April 2013 provided by the facility, prior to tracheostomy care observation for Resident #67, indicated in part, "Note: If using disposable trach care kit for changing of inner cannula, follow manufacturer's directions". On 11/20/19 a review of the manufacturer's guidelines for Resident #67's disposable inner tracheostomy cannula provided by the facility read in part, "The disposable inner cannula is designed for single use and should not be cleaned or reused". Resident #67 was admitted to the facility on 10/10/19 with diagnosis including tracheostomy (a surgical procedure to insert a breathing tube through an opening in the neck). An admission Minimum Data Set assessment dated 10/16/19 indicated Resident #67 was rarely	F 695	F 695 On 11/22/2019, tracheostomy care was provided to resident # 67 by the assigned hall nurse per the manufacturer□s guidelines. On 12/13/2019 return demonstrations were initiated by the Facility Consultant with Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Unit Managers and hall nurses to include Nurse # 4 to ensure tracheostomy care was provided per the manufacturer□s guidelines. To be completed by 1/6/2020. On 12/12/2019 an in-service was initiated by the Facility nurse consultant with Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, Unit Managers and hall nurses on providing tracheostomy care per the manufacturer guidelines to include not cleaning and reusing the disposable inner cannula. The in-service will be completed by 1/6/2020. All newly hired DON□s, ADON□s Unit Managers or nurses to include agency will be in-serviced during orientation by the Staff Facilitator (SF) regarding providing tracheostomy care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 695	Continued From page 39 if ever understood, had memory problems, was impaired for daily decision making and an altered level of consciousness and inattention were continuously present. It further indicated Resident #67 had no behaviors or rejection of care, was totally dependent on staff for all activities of daily such as bathing and personal hygiene, and received oxygen therapy, suctioning and tracheostomy care. A care plan dated 10/10/19 for Resident #67 indicated a focus area of potential for ineffective breathing pattern related to tracheostomy and history of acute respiratory failure with a goal of resident's airway will be maintained through next review and interventions including tracheostomy care as ordered by physician or facility protocol. On 11/19/19 at 3:49 PM an observation of tracheostomy care for Resident #67 was conducted in the facility with Nurse #4. Nurse #4 was observed to remove Resident #67's inner tracheostomy cannula and clean it with hydrogen peroxide and distilled water using sterile technique. She was then observed to reinsert the same inner cannula into Resident #67's tracheostomy indicating she was finished. When asked to look closely at the end of Resident #67's inner cannula and read the words indicated in red to the surveyor Nurse #4 stated, "Do not clean, Do not reuse". Nurse #4 indicated she had not realized Resident #67's inner tracheostomy cannula was disposable, and she should not have cleaned and reinserted it. Nurse #4 indicated when she last cared for Resident #67, she believed the inner cannula had been non-disposable. She then removed Resident #67's inner cannula, disposed of it and replaced it with a new sterile disposable inner cannula.	F 695	per the manufacturer guidelines to include not cleaning and reusing the disposable inner cannula. All residents with tracheostomy□s to include Resident # 67 will monitored by the Unit Managers weekly for 8 weeks and monthly for 1 month utilizing a Trach Care Audit tool to ensure tracheotomy cleaned per the manufacturer□s guidelines. Any areas of concern identified during the audit will be addressed immediately by the Unit Managers. The DON will review and initial the Trach Care Audit tool weekly for 8 weeks and monthly for 1 month to ensure completion and that all areas of concerns are addressed. The DON will present the findings of the Trach Care Audit tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Trach Care Audit tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 695	Continued From page 40 On 11/19/19 at 4:44 PM interview with the DON and Administrator indicated the disposable inner cannula for Resident #67's tracheostomy was a stock item in the facility. They further indicated to their knowledge Resident #67 had a disposable inner tracheostomy cannula since her admission to the facility on 10/10/19 and staff should not be cleaning and reusing it. They indicated staff should be following best practice and the manufacturer's guidelines when providing care to residents and cleaning and reusing a disposable inner tracheostomy cannula placed Resident #67 at risk for negative consequences such as infection. On 11/20/19 at 8:05 AM telephone interview with Nurse #5 indicated she was familiar with Resident #67 and provided tracheostomy care to her. Nurse #5 stated to her knowledge Resident #67 had a disposable inner tracheostomy cannula since her admission to the facility. She went on to say the inner cannula had the words, "Do not clean, Do not reuse" in red at the top of the cannula. She stated she always disposed of the cannula and reinserted a new one when she provided tracheostomy care to Resident #67. On 11/20/19 at 9:17 AM telephone interview with Nurse #6 indicated she was familiar with Resident #67 and had cared for her often. Nurse #6 stated to her knowledge Resident #67 had a disposable inner tracheostomy cannula since her admission to the facility. She further indicated Resident #67's inner cannula had the words "Do not clean, Do not reuse" in red at the top of the cannula and she always disposed of it and reinserted a new one when she provided tracheostomy care to Resident #67.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 695	Continued From page 41 On 11/20/19 at 4:10 PM an interview with Physician #1 indicated he would expect all staff to be following the manufacturer's guidelines when changing the inner cannula during tracheostomy care for Resident #67 and if the cannula and the guidelines indicated not to clean or reuse the cannula staff should not be doing that. He went on to say to his knowledge Resident #67 had not experienced any adverse consequences from having her disposable inner cannula cleaned and reinserted, had not suffered any respiratory infections since her admission to the facility and did not currently have any signs of respiratory distress or infection.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 700	Continued From page 42 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility utilized bed side rails on a resident's bed who was assessed not to have side rails in place for 1 of 1 residents reviewed for bed side rails. (Resident #3) Findings included: Resident #3 was admitted to the facility on 3/11/2009. Her active diagnosis included hypertension and Alzheimer's disease. Resident #3's care guide revealed an intervention created 12/8/17 specified Resident #3 was not to have bed rails. Resident #3's most recent bed rail assessment dated 6/4/18 revealed side rails were not indicated for Resident #3. Resident #3's minimum data set assessment dated 10/30/19 revealed she was assessed as severely cognitively impaired. She required extensive assistance with bed mobility and was totally dependent on staff for dressing, eating, toilet use, and personal hygiene. During observation on 11/18/19 at 10:57 AM Resident #3 was observed in bed. Bilateral quarter side rails were in place and up. During observation on 11/18/19 at 2:27 PM Resident #3 was observed in bed. The bed's side rails were observed to be up.	F 700	F 700 On 11/19/2019 resident # 3□s bed rails were removed from resident□s bed by the maintenance supervisor. On 12/12/2019 a 100% audit was initiated by the Assistant Director OF Nursing (ADON) of all residents to include resident # 3 utilizing a census to ensure the residents have been properly assessed for the use/removal of bed rails and care plans updated. Any areas of concerns were addressed during the audit. Audit was completed on 12/17/2019. On 12/12/2019 an in-service on Bed Rails was initated by the Facility Consultant with the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Facilitator, MDS Coordinator, MDS Nurse, Unit Managers and hall nurses in regards to use of bed rails to include: If bed rail use is indicated for a resident the nurse must assess the resident utilizing the Physical Device Evaluation. The bed rails are to be reviewed quarterly if used to include completing the Physical Device Evaluation. Nurse must ensure that the risk and benefits are explained to the resident and/or resident representative if bed rails are used. If bed rails are used resident must be care planned for the use of the bed rails. In-service to be completed by 1/6/2020. All newly hired DON, ADON, Staff Facilitator, MDS Coordinator, MDS Nurse, Unit Managers and hall nurses will be in-serviced by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 700	Continued From page 43 During observation on 11/18/19 at 3:48 PM Resident #3 was observed to have both quarter bed rails raised. Resident #3 was lying on her right side and her right hand was on the right-side rail. She had pulled her legs up in the fetal position. Her left foot was planted against the right-side rail. Her right foot was partially through a space in the right-side rail with the sole of her foot against the diagonal of the right-side rail. During observation on 11/19/19 at 8:40 AM Nurse Aide #3 was observed assisting Resident #3 with breakfast. The resident was in bed and both of the bed's quarter side rails were observed up. When the nurse aide finished assisting Resident #3, she left the resident's room with the resident in bed and both of the bed's side rails remained up. During observation on 11/19/19 at 1:04 PM Nurse Aide #3 was observed assisting Resident #3 with lunch. The bilateral quarter side rails were observed to have the right one up and the left one down so the bedside table would go over the bed. At 1:24 PM the nurse aide left the room with the resident in bed. The bed's right-side rail was still up while the left side rail was left down. During an interview on 11/19/19 at 1:40 PM Nurse Aide #3 stated Resident #3 could not put her side rails up or down. She further stated if a family member requested side rails, the request would go to the nurse. She further stated the side rail status of residents was not made available to her. The nurse aide continued to state she was not aware Resident #3 was not supposed to have the side rails according to the care guide. The nurse aide then pulled up the care guide for Resident	F 700	Staff Facilitator during orientation in regards to use of bed rails to include: If bed rail use is indicated for a resident the nurse must assess the resident utilizing the Physical Device Evaluation. The bed rails are to be reviewed quarterly if used to include completing the Physical Device Evaluation. Nurse must ensure that the risk and benefits are explained to the resident and/or resident representative if bed rails are used. If bed rails are used resident must be care planned for the use of the bed rails. 10 % audit of all residents with use and/or removal of bed rails to include resident # 3 will be completed by the Staff Facilitator weekly x 8 weeks, then monthly x 1 month utilizing the Bed Rail Audit Tool to ensure assessment for the use and/or removal of bed rails has been completed. The DON will review the Bed Rail Audit Tool weekly x 8 weeks, then monthly x 1 month to ensure completion and that all areas of concern were addressed. The DON will forward the results of the Bed Rail Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Bed Rail Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 700	Continued From page 44 #3 on a facility computer tablet. Upon observing the care guide, she agreed it indicated Resident #3 should have no side rails. Upon observing the care guide the nurse aide stated she did not know it was on the care guide and Resident #3 had bed rails up and in use since at least five months ago when she started working in the facility. The nurse aide concluded Resident #3 had bed rails the entire time she cared for her, so she thought Resident #3 was supposed to have side rails. During an interview on 11/19/19 at 1:46 PM Nurse #1 stated Resident #3 would use the bed rails in order to pull herself around. She further stated she thought Resident #3 needed the bed rails. She further stated the staff had to get the Director of Nursing to get permission to get side rails and indicated the Director of Nursing would know more about if Resident #3 was supposed to have side rails. During an interview on 11/19/19 at 1:51 PM the Director of Nursing stated when residents get side rails, the request should go through her. She further stated Resident #3 was not supposed to have side rails for safety reasons. The Director of Nursing stated when Resident #3 was moved to a different room, she was probably placed in a different bed which resulted in her having side rails. She stated it had not been very long. She concluded staff should have followed the assessment and care guide and removed the side rails from the bed for Resident #3.	F 700		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 812	Continued From page 45 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date milk shakes after removal from the freezer in order to track the shelf life for 138 out of 138 milk shakes; failed to use an ice scoop in a manner to prevent contamination; and failed to keep dirty and clean dishes separate in the kitchen. The findings included: 1. During the initial tour of the facility kitchen on 11/18/19 from 9:25 AM-9:50 AM an observation was made of 138 undated chocolate and vanilla milk shakes thawed in a reach-in refrigerator. The manufacturer instructions stamped on each carton of milk shake indicated the product had a shelf life of 14 days after being thawed. An interview with the Dietary Manager (DM) on	F 812	F812 On 11/18/2019 the 138 milk shakes were discarded by the Corporate Dietary Consultant. On 11/18/2019 the ice scoop was cleaned and placed in the ice scoop holder by the Dietary Manager. On 11/19/2019 the clean plate covers were cleaned by the Dietary aide. On 11/20/2019 unlabeled items were removed from the ICF nourishment refrigerator by the hall nurse. On 12/20/19 a 100% Audit of the refrigerator was completed by the Administrator to ensure milk shakes are dated and not past the 14 day use. The Dietary Manager immediately removed any milk shakes that were not dated or past the 14 day date. On 12/20/19 the Administrator observed that the ice scoop was in the ice scoop holder not on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 812	Continued From page 46 11/18/19 at 9:35 AM indicated she was unaware the milk shakes were supposed to have an expiration date of 14 days after being thawed. She further stated she was unaware of the manufacturer's recommendation of 14 days after being thawed and had failed to date them after they were taken out of the freezer. An interview with the Corporate Dietary Consultant on 11/18/19 at 9:45 AM indicated she was aware the milk shakes were supposed to have an expiration date of 14 days after being thawed and staff did not have a system in place to prevent the milk shakes from being utilized 14 days after being thawed. An interview with the Administrator on 11/21/19 at 9:18 AM indicated the kitchen should follow manufacturer's guideline for the milk shakes to be dated appropriately. 2. During a lunch meal set up observation on 11/19/19 from 11:45 AM until 12:05 PM, Dietary Aide (DA) #1 was observed to take an ice scoop from the kitchen, scoop ice from the ice machine with ice and carry it to the serving line and pour the ice over 2 containers filled with drink cartons which included: milk boxes, juice boxes, boost boxes, resource boxes, and glucose control boost boxes. DA #1 was then observed to use the ice scoop from the ice machine to pat and level the ice over the food items in the containers. DA #1 then carried the ice scoop to the ice machine and got another scoop of ice, put it in a pitcher and placed the ice scoop on the kitchen counter surface. DA #1 was observed to put the ice from the pitcher on top of the drink cartons and then return to the ice scoop on the kitchen counter surface, pick the scoop up, and place it in the ice	F 812	counter. On 12/20/2019 the Administrator observed that no dirty drink trays were noted on the clean plate covers. All identified areas of concerns were corrected by the Dietary Manger during the audit. A 100% In-service was initiated on 12/13/2019 by the Facility Nurse Consultant with Dietary manager, dietary aides and cooks in regards to: ensuring that milk shakes are date when removed from freezer and discarded within 14 days if not used, ice scoops are not to be used to level ice over cartons or cups and ice scoops should be immediately placed back in ice scoop holder after use. Never place dirty drink trays on top of clean plate covers. In-service to be completed on 1/6/2020.All newly hired dietary employees to include dietary managers, dietary aides and cooks will be in-serviced regarding ensuring that milk shakes are date when removed from freezer and discarded within 14 days if not used, ice scoops are not to be used to level ice over cartons or cups and ice scoops should be immediately placed back in ice scoop holder after use. Never place dirty drink trays on top of clean plate covers. A 100% in-service was initiated by the 12/12/2019 with all nurses and nursing assistants(NA) by the Staff Facilitator in regards to labeling and dating food items brought in by families for residents prior to placing in the nourishment refrigerator. In-service to be completed by 1/6/2020. All newly hired nurse and nursing assistants will be educated by the Staff Facilitator in orientation in regards to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 812	Continued From page 47 scoop holder mounted on the wall. An interview with DA #1 on 11/19/19 at 1:25 PM, she stated she normally used the ice scoop as a "rake to level the ice" over the drink cartons. She further stated the ice scoop was supposed to be placed back in the scoop holder and not placed on the kitchen counter and she did not know why she had put the ice scoop on the counter before putting it in the scoop holder. An interview with the Dietary Manager (DM) on 11/18/19 at 9:35 AM indicated she was unaware that DA #1 had used the ice scoop as a rake on top of the drink cartons or that she had placed the ice scoop on the counter. She stated the ice scoop should not be used on top of drink cartons or placed on the kitchen counter. An interview with the Administrator on 11/21/19 at 9:18 AM indicated the kitchen staff should be following infection control policies and facility guidelines to ensure resident safety. 3. During the lunch meal tray plating observation on 11/19/19 from 12:05 PM until 12:40 PM, Dietary Aide (DA) #2 was observed to place 3 used drink trays on the clean shelf with clean plate covers. An interview with DA #2 on 11/19/19 at 1:30 PM revealed she usually puts the used drink trays in the sink. She stated today she felt rushed and put them on the shelf with the clean plate covers instead of taking them to the sink. DA #2 confirmed she knew not to put dirty dishes on the shelf with clean dishes. An interview with the Dietary Manager (DM) on	F 812	labeling and dating food items brought in by families for residents prior to placing in the nourishment refrigerator. The Activities Assistant will audit the refrigerator to ensure no milk shakes are noted in the refrigerator undated or dated past 14 days utilizing Dietary Audit Tool weekly X 8 weeks then monthly X 1 month. The Dietary Manager will remove any milk shakes that are not dated when removed from the freezer. The Activities Assistant will observe the tray line utilizing the Dietary Audit tool weekly for 8 weeks and monthly for 1 month to ensure if ice scoop is removed from ice scoop holder that it not used to pat ice over items and placed back in the ice scoop holder and that dirty drink trays are placed in the sink not on top of clean plate covers. The Dietary Manager will addressed any identified concerns during the audit. The Activity Assistant will audit the nourishment refrigerators utilizing the Nourishment Refrigerator tool weekly for 8 weeks and monthly for 1 month to ensure that all outside resident□s food is labeled and dated when placed in the nourishment refrigerator. The DON will address any identified areas of concerns during the audit. The Administrator will review and initial the Dry Storage Audit Tool and the Nourishment Refrigerator tool weekly X 8weeks then monthly X 1 month to ensure completion and that all areas of concerns have been addressed. The Administrator will forward results of the Dietary Audit Tool and the Nourishment Refrigerator tool to the Executive QA Committee monthly X 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 812	Continued From page 48 11/18/19 at 9:35 AM indicated she was unaware that DA #2 had placed dirty dishes on the shelf with clean dishes and stated her staff should place dirty dishes in the dishwashing area and not with clean dishes. An interview with the Administrator on 11/21/19 at 9:18 AM indicated the kitchen staff should be following infection control policies and guidelines to ensure resident safety. 4. During an observation on 11/20/19 at 11:10 AM the ICF Hall nourishment refrigerator was observed to have a fast food restaurant take out bag with a cheeseburger and apple pie inside. Neither the bag nor the items were labeled or dated. The refrigerator also contained a package of Peanut Butter Cups and two bottles of tea. These items were not labeled or dated either. During an interview on 11/20/19 at 11:11 AM Nurse #1 stated the candy, the cheeseburger, apple pie and tea should have been labeled and dated. She stated the family member bring items to the nurse and the nurse must label and date the items and place them in the nourishment refrigerator. During an interview on 11/20/19 at 11:43 AM the Director of Nursing stated whenever family brought food for a resident or if a resident asked for food to be stored in the nourishment refrigerator the staff should label and date the items. During an interview on 11/20/19 at 1:11 PM the Dietary Manger stated food items stored in the nourishment refrigerator should be labeled and dated.	F 812	months. The Executive QA Committee will meet monthly X 3 months and review the Dietary Audit Tool and the Nourishment Refrigerator tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further and/or frequency of monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep the dumpster area free of a large accumulation of debris for 2 of 2 dumpsters. Findings included: Observations of the facility's dumpster area on 11/20/19 at 8:35 AM with the Dietary Consultant revealed a large pile of accumulated used equipment, used furniture and debris behind the 2 facility dumpsters. Items included in this large pile were: a walker, 3 wheelchairs, a bed, 2 televisions, a nightstand, an air conditioner unit, 6 long aluminum poles, 2 toilets, parts of a medication cart, 3 crates, 2 buckets of debris including sand bags and blankets, 8 pallets, a door, a pile of broken concrete pieces, and food wrappers. Other debris spread around the dumpster area included pieces of food wrappers, used gloves, and plastic cups. There was standing water in the 2 buckets. There was no signs of rodents or pests. On 11/20/19 at 8:35 AM, an interview was conducted with the Maintenance Assistant who stated the large pile of debris, observed behind the two facility dumpsters, had been there about a month. He also stated he had not contacted anyone to remove the debris. On 11/20/19 at 8:37 AM, an interview was conducted with the Maintenance Director who stated he was aware of the large pile of debris,	F 814	F 814 On 11/23/2019 the large accumulation of debris was removed from the dumpster area by the Maintenance Supervisor. On 12/18/2019 an audit was completed by the Administrator of the dumpster areas to ensure that there was no large accumulation of debris. The Maintenance supervisor will address any identified areas of concern during the audit to include removing the debris. On 12/13/2019 an in-service was initiated by the Administrator with the Maintenance supervisor, maintenance assistant, Dietary Manager and dietary aides in regards to not allowing large amounts of debris to accumulate around the dumpster area. In-service to be completed by 1/6/2020. The Dumpster areas will be audited by the Activities Director utilizing a Dumpster Audit Tool weekly for 8 weeks and monthly for 1 month to ensure that large amounts of debris is not noted around the dumpster areas. The Maintenance supervisor and/or assistant will address any identified areas of concerns noted during the audit. The Administrator will review and initial the Dumpster Audit Tool weekly for 8 weeks and monthly for 1 month to ensure completion and that all areas of concerns were addressed. The Administrator will forward the results	1/6/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345145	A. BUILDING _____ B. WING _____	C 11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE RIVER NURSING AND REHABILITATION CENTER	119 GATLING STREET WILLIAMSTON, NC 27892

(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 814	Continued From page 50 behind the two facility dumpsters, and it had been there about 2 months. He also stated there used to be a man who came weekly to haul it away but did not currently have anyone who could haul it away. During an interview with the Dietary Manager on 11/20/19 at 8:52 AM, she stated the pile of debris, observed in the dumpster area, had been placed there by maintenance staff and she was unaware of how to get it removed from the facility. During an interview with the Administrator on 11/21/19 at 9:18 AM, she stated the area around the dumpster should be kept free of debris.	F 814	of the Dumpster Audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA committee will meet monthly x 3months and review the Dumpster Audit Tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	