STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING ______ B. WING ______	C 11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE AT ROCKY MOUNT HEALTH AND REHABILITATION	3322 VILLAGE ROAD ROCKY MOUNT, NC 27804

(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 and complaint investigation survey was conducted on 11/07/22 through 11/10/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LZA411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/07/22 through 11/10/22. Event ID# LZA411. The following intakes were investigated NC00190702, NC00190324, NC00193089, and NC00191616. 6 of the 6 complaint allegations were not substantiated.	F 000		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625		11/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE: | (X6) DATE: 11/23/2022

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

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F 625	Continued From page 1 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Responsible Party interview, the facility failed to notify the Resident or Resident Representative of the facility bed hold policy for 1 of 3 residents reviewed for hospitalization (Resident #84). The findings included: Resident #84 was admitted to the facility on 11/01/21. Record review of Resident #84's medical record revealed he was discharged to the hospital on 5/16/22, 6/01/22, and 10/10/22. During an interview on 11/08/22 at 8:30 am Resident #84's Responsible Party (RP) revealed she had not received a notice of the bed hold policy when Resident #84 was discharged to the hospital. During an interview on 11/08/22 at 3:24 pm the Administrator stated the facility had not provided the bed hold policy to the Resident or the RP upon discharge to the hospital for Resident #25 and Resident #84. The Administrator stated the facility was not aware of the requirement to provide the bed hold policy when a resident was discharged to the hospital.	F 625	F625 Notice of Bed Hold Policy Before/Upon Transfer Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On November 8th, 2022, resident #84 responsible party revealed that she had not received a bed hold policy when resident was discharged to the hospital. On November 8th, 2022 it was identified that all residents and families had the potential to be affected by this practice. On November 9th 2022, education was provided to the Administrator; Director of Nursing and Resident Liaison on the Bed Hold Policy and the regulation. Education began for all Licensed Nursing Staff on November 10th, 2022, on giving a copy of the Bed Hold Policy at the time the resident is discharged to the hospital and	

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F 625	Continued From page 2 During an interview on 11/10/22 at 10:23 am the Director of Nursing (DON) stated when a resident was discharged to the hospital a face sheet and continuity of care document which included diagnoses, code status, and medications was sent with the resident. The DON stated the facility was not aware the bed hold policy was required to be sent for discharges to the hospital for Resident #84.	F 625	to document this in the resident's medical record. All Licensed Nursing Staff will be educated by November 24th, 2022 or will not work until educated. On November 10th 2022, resident Liaison and Business Office Manager were educated on completing a follow up call within 72 hours of discharge to hospital to explain the Bed Hold Policy to the Resident or Resident's Responsible Party and to document conversation in the resident's medical record. The Director of Nursing, Resident Liaison or other designee will audit all discharges to the hospital for three months to ensure compliance with the Bed Hold Policy. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial compliance is November 24, 2022.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		11/24/22

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F 656	Continued From page 3 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews, and staff interviews, the facility failed to develop a personalized care plan related to personal preference for 1 of 23 residents reviewed for care plan (Resident #28). The findings included: Resident #28 was admitted to the facility on 1/12/20. Record review of the Grievance Report dated 7/27/22 revealed Resident #28 reported he was often getting out of bed either earlier or later than requested. The resolution was to have staff get Resident #28 out of bed as early as preference except on wound rounds day. The education was signed by nursing staff. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 8/14/22 revealed Resident #28 had moderate cognitive impairment, had clear speech, and was able to be understood. Resident #28 was total dependence for transfers by 2-person physical assist. Record review of Resident #28's care plan last revised on 10/07/22 revealed no care plan for Resident #28's preference to be out of bed early. During an interview on 11/07/22 at 11:22 am Resident #28 stated he had asked the staff to have him out of bed before 10:00 am. Resident #28 stated he understood that on wound round days he would have to wait longer to get out of bed but on the other days of the week he would like to be out of bed before 10:00 am and the	F 656	F 656 Develop/Implement Comprehensive Care Plan Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. During Annual Survey conducted November 7th, 2022, through November 10th 2022 it was identified that the facility failed to develop a personalized care plan for 1 of 23 residents reviewed for care plans. Resident #28 reported that his preference was to get out of bed early. On review of Quarterly Assessment dated October 7th, 2022, revealed no care plan for Resident #28 preference to get out of bed early. On November 22nd, 2022 Resident #28's care plan was updated to include Resident's preference to get out of bed early. On November 22nd, 2022 all current residents with a grievance in the past three months regarding issues with getting out of bed were reviewed to ensure their care plan included preferences to get out of bed at requested time. On November 22nd 2022, MDS	

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F 656	Continued From page 5 facility was aware of his request. During an interview on 11/09/22 12:26 pm the MDS Nurse revealed she was not sure if Resident #28's preference to be out of bed early was required to be added to the care plan. During an interview on 11/10/22 at 9:59 am Nurse Aid (NA) #1 revealed she was aware of Resident #28's preference to be out of bed early because she is assigned to his care often but did not know where to locate the information. NA #1 stated Resident #28 does become upset when he cannot get out of bed early. During an interview on 11/10/22 at 10:25 am the Director of Nursing (DON) revealed she was unsure if a personal preference for Resident #28 was care planned. The DON was unable to state why Resident #28's personal preference for getting up early was not included in the care plan.	F 656	Coordinator and Activities Director were educated by the Regional MDS Manager and Administrator on appropriateness of care plans to include resident preferences. The MDS Coordinator will complete five care plan audits weekly for resident's preferences for four weeks; then three chart audits weekly for four weeks the one chart audit for four weeks. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial compliance is November 24, 2022	
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 - §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	F 812		11/24/22

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F 812	Continued From page 6 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: 1) maintain 2-chef salads with egg, at 41 degrees fahrenheit (F) or below on the lunch meal tray line. Both salad items could be potentially hazardous if not served at the appropriate temperatures. The findings include: An observation of the lunch meal tray line on 11/07/22 at 11: 20 AM and 12:15 PM. Temperature monitoring, with the Dietary Manager on 11/07/22 at 12:20 PM revealed the following temperatures: chef salads 52 degrees F. During an interview with the Dietary Manager on 11/07/22 at 12:35 PM, she stated that she expected dietary staff to serve cold foods 41 degrees F. or below. and if cold foods were higher than 41-degrees F., the food items should be discarded prior to serving. She also stated the chef salads should have been kept cool below 41 degrees F. just prior to serving and was not. During an interview with the Director of Dietary	F 812	F 812 Food Procurement, Store/Prepare/serve Sanitary Preparation and/or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. On November 7th, 2022, an observation of the lunch meal tray line revealed the following temperatures: chef salads 52 degrees F. Once identified the salads were immediately discarded and not served to any residents. All other foods were then tempted to ensure safety standards were being met. No other issues identified. On November 22nd, 2022, education was started on obtaining temperatures at the	

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F 812	Continued From page 7 Services on 10/08/21 at 8:20 AM, she revealed hot food temperatures were required to be below 41 degrees F. when served from the tray line. During an interview with the Administrator and Director of Nursing (DON) on 10/09/21 at 12:15M, they both reported it was their expectation the facility's kitchens follow all regulatory guidelines for food and kitchen sanitation safety.	F 812	beginning and during meal service. Additionally, education on new process of storing salads in the reach in refrigerator instead on ice until served was implemented. All dietary staff will be educated on temperature checks as well as new salad storage process by November 24, 2022. Any dietary staff not educated by November 24, 2022, will not be able to work until educated. The Lodge at Rocky Mount Health and Rehabilitation will monitor the corrective plan to ensure the practice was corrected by utilizing a Quality Improvement (QI) Audit Tool, to review temperature logs for correct temperatures. The monitoring will occur at least five time a week including weekends for four weeks, then three times a week for four weeks, and then one time a week for four weeks to monitor for trends or concerns by the Dietary Manager. Results of the audit will be reviewed in the monthly facility Quality Assurance and Performance Improvement Committee for three months. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained, ongoing, and determine the need for further auditing beyond the three months. The Quality Assurance committee can modify this plan to ensure the facility remains in substantial compliance. The correction date for substantial	

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F 812	Continued From page 8	F 812	compliance is November 24, 2022.	