CENTERS FOR MEDICARE & MEDICARD SERVICES         OME NO 0988-029           STREEMER OF DEFICIENCES         (X3) DATE SURVEY           NOME OF PROVIDER OR SUPPLIER         IDENTIFICATION NUMBER:           ABULDING         345266           NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CTY, STATE, 2/P CODE           Tobus US 46 EAST         PLOTERS FOR MEDICARD SENDED           PROVIDER OR SUPPLIER         STREET ADDRESS, CTY, STATE, 2/P CODE           ROANCE LANDING NURSING AND REHABILITATION CENTER         THEET ADDRESS, CTY, STATE, 2/P CODE           ROANCE LANDING NURSING AND REHABILITATION CENTER         THEET ADDRESS, CTY, STATE, 2/P CODE           ROANCE LANDING NURSING AND REHABILITATION CENTER         THE PROVIDER OR SUPPLIER         06/18/2015           ROANCE LANDING NURSING AND REHABILITATION CENTER         PROVIDER OR SUPLAY OF ORDERCTION IN FULL         TO PROVIDER OR SUPPLIER         06/18/2016           ROANCE LANDING NURSING AND REHABILITATION CENTER         ID PREYN         CROSS-REFERENCE TO THE APROPREATE         06/18/2016           Set DMARK SCHECHOLCES         The resident the order of resident.         PROVIDER OR SUPLAY OF SCHEMENT         7/16/15           The resident the facility on resident.         This REQUIREMENT is not met as evidenced by:         F1/2         Roanoke Landing Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and in order to maintain convolating and Rehabilitation			AND HUMAN SERVICES		FO	ED: 07/17/2015 RM APPROVED
MAKE OF PROVIDER OR SUPPLIER       STREET ADDRESS. CITY. STATE, ZIP CODE         YOA ID       SUMMARY STREMENT OF DEFICIENCIES         YOA ID       SUMMARY STREMENT OF DEFICIENCIES         TAG       SUMMARY STREMENT OF DEFICIENCIES         PREFX       SUMMARY STREMENT OF DEFICIENCIES         TAG       SUMMARY STREMENT OF DEFICIENCIES         PREFX       SUMMARY STREMENT OF DEFICIENCIES         TAG       SUMMARY STREMENT OF DEFICIENCIES         SSSED       SUMMARY STREMENT OF DEFICIENCIES         SSSED       MAKE CHOICES         The resident has the right to choose activities, schedules, and health care consistent with his or her interesta, assesments, and plans of care; interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility on 3331/2015, with diagonoses to include Alzbeimer's disease, congestive heart failure, and hypotension. Her admission Minimum Data Set (MDS) assessment dated 4/9/2015, revealed her cognition to be intact. She was always continent with blader and bowel.         During a medication pas observation on 6/17/2015, at 7:55 AM, Nurse #1, and et as (a durite) care of residents. The resident Howel the more at a time. The resident proved the pills in the resident trapuested to take her as (a durite) care of residents. The resident proved the pills in the rand and stated she liked to take the tas (a durite) care of residents. The resident proved the pills in the rand and state divend to take her as (a durite) care of residents. The resident trapuested to take her tas (a durite) care of residents. The resident the ta	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION (X3)	DATE SURVEY
ROANCKE LANDING NURSING AND REHABILITATION CENTER         1094 US 64 EAST PLYMOUTH, NC 27962           (PA) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LS DENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         COMPLETING (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         COMPLETING (CACH CORRECTIVE TAG         PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         COMPLETING (CACH CORRECTIVE TAG         COMPLETING (CACH CORRECTIVE TAG         COMPLETING (CACH CORRECTIVE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         COMPLETING (CACH CORRECTIVE (CACH CORRECTIVE TAG         PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE CROSS-REFERENCED TO THE APROPRIATE DEFICIENCY)         COMPLETING (CACH CORRECTIVE TAG         PROVIDER'S FLAN OF CORRECTION (CACH CORRECTIVE TAG         COMPLETING (CACH CORRECTIVE TAG         PROVIDER'S FLAN OF CORRECTION (CACH CORRECTIVE TAG         COMPLETING (CACH CORRECTIVE TAG (CACH CACH CORRECTIVE TAG         COMPLETING (CACH CACH CA			345266	B. WING		06/18/2015
ROANCRE LANDING NURSING AND REHABILITATION CENTER         PLYMOUTH, NC 27962           (W1)D PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MARTE BREACEDE BY FULL RECULATORY OR LSC DENTFYING INFORMATION)         D PREFX PAGE         PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MARTE BREACEDE BY FULL RECULATORY OR LSC DENTFYING INFORMATION)         D PREFX TAG         PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY WASTE BREACEDE BY FULL RECULATORY OR LSC DENTFYING INFORMATION)         D PREFX TAG         PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY)         (%0) (EACH DEFICIENCY (EACH DEFICIENCY WASTE BREACED BY FULL RECULATORY OR LSC DENTFYING INFORMATION)         D PREFX TAG         PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY)         (%0) (EACH DEFICIENCY (EACH DEFICIENCY (EACH DEFICIENCY)           F 242         483.15(b) SELF-DETERMINATION - RIGHT TO SS=D MAKE CHOICES         F 242         F 242         F 242         7/16/15           This resident has the right to choose activities, schedules, and health care consistent with his or her interest, assessments, and plans of care; interact with members of the community both inside and outside the facility and are resident to the resident.         F 242         Roanoke Landing Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.           Notate the plan share at tains. The regoing ato the bediate table and asked the nurse, 'Are you	NAME OF F	PROVIDER OR SUPPLIER	•		•	
Prefers         reach depricency wurst be preceded by PutL REGULATORY OR LSC IDENTIFYING INFORMATION)         Prefers Tag         reach depricency         consistent DEFICIENCY)         consistent DEFICIENCY         consistent DEFICIENCY <t< td=""><td>ROANO</td><td>E LANDING NURSIN</td><td>IG AND REHABILITATION CENTE</td><td>RI</td><td></td><td></td></t<>	ROANO	E LANDING NURSIN	IG AND REHABILITATION CENTE	RI		
SS=D       MAKE CHOICES         The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of charry interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.         This REQUIREMENT is not met as evidenced by:       Based on observation, record review and staff and resident interviews, the facility failed to allow the resident to choose to take her medication at a later time. The findings included:       Roanoke Landing Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.         During a medication pass observation on 6/17/2015, at 7:55 AM, Nurse #2 handed Resident #104 her medication cup with β pills in it. The resident poured the pills in her hand and stated she liked to take them one at a time. The resident requested to take her Lasix (a diuretic) after bingo that morning, so she would not have to go to the bathroom during bingo. The nurse tol her she had already take the Lasix? The nurse replied that the pill was not Lasix. After going back coutside the room to the medication care, the nurse was asked what pill the last one was. The	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
schedules, and health care consistent with his or her intereact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff and resident interviews, the facility failed to allow the resident to choose to take her medication at a later time. The findings included: Resident #104 was admitted to the facility on 3/31/2015, with diagnoses to include ALPiener's disease, congestive heart failure, and hypertension. Her admission Minimum Data Set (MDS) assessment dated 4/9/2015, revealed her cognition to be intact. She was always continent with bladder and bowel. During a medication pass observation on 6/17/2015, sti 7:55 AM, Nurse #2 handed Resident #104 her medication cup with 8 pills in it. The resident poured the pills in her hand and stated she liked to take her Lasix (aluretic) after bingo that morning, so she would not have to go to the bathroom during bingo. The nurse you sure this one isn't the Lasix ?" The nurse replied that the pill was not Lasix. After going back coutside the room to the medication cart, the nurse was asked what pill the last one was. The			ETERMINATION - RIGHT TO	F 242	2	7/16/15
by: Based on observation, record review and staff and resident interviews, the facility failed to allow the resident to choose to take her medication at a later time. The findings included: Resident #104 was admitted to the facility on 3/31/2015, with diagnoses to include Alzheimer's disease, congestive heart failure, and hypertension. Her admission Minimum Data Set (MDS) assessment dated 4/9/2015, revealed her cognition to be intact. She was always continent with bladder and bowel. During a medication pass observation on 6/17/2015, at 7:55 AM, Nurse #2 handed Resident #104 her medication cup with 8 pills in it. The resident poured the pills in her hand and stated she liked to take her one at a time. The resident requested to take her lasix (a diuretic) after bingo that morning, so she would not have to go to the bathroom during bingo. The nurse told her she had already taken the Lasix pill. When the resident got to her last pill, she laid it on the bedside table and asked the nurse, "Are you sure this one isn't the Lasix?" The nurse replied that the pill was not Lasix. After going back outside the room to the medication cart, the nurse was asked what pill the last one was. The		schedules, and hea her interests, asses interact with memb inside and outside about aspects of hi	alth care consistent with his or ssments, and plans of care; ers of the community both the facility; and make choices is or her life in the facility that			
nurse was asked what pill the last one was. The choices honored and receive medication		by: Based on observa and resident intervi the resident to choo later time. The find Resident #104 was 3/31/2015, with dia disease, congestive hypertension. Her (MDS) assessment cognition to be inta with bladder and be During a medicatio 6/17/2015, at 7:55 Resident #104 her it. The resident pos stated she liked to resident requested after bingo that moo to go to the bathroot told her she had all When the resident on the bedside tabl you sure this one is replied that the pill	tion, record review and staff lews, the facility failed to allow ose to take her medication at a dings included: a admitted to the facility on gnoses to include Alzheimer's e heart failure, and admission Minimum Data Set t dated 4/9/2015, revealed her ct. She was always continent owel. n pass observation on AM, Nurse #2 handed medication cup with 8 pills in oured the pills in her hand and take them one at a time. The to take her Lasix (a diuretic) rning, so she would not have om during bingo. The nurse ready taken the Lasix pill. got to her last pill, she laid it le and asked the nurse, "Are sn't the Lasix?" The nurse was not Lasix. After going		Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents The Plan of Correction is submitted as a written allegation of compliance. Roanoke Landing Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accura Further, Britthaven reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	is n s. a if te.
	ABORATOR	nurse was asked w	hat pill the last one was. The	NATURF	choices honored and receive medicatio	

07/07/2015

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

**Electronically Signed** 

		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345266	B. WING			06/*	18/2015
	Provider or Supplier	G AND REHABILITATION CENTE	R	1(	TREET ADDRESS, CITY, STATE, ZIP COD 084 US 64 EAST LYMOUTH, NC 27962		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 242	she only had until 9 mediation, or she w resident her Lasix a even start until 10:0 asked if residents e medication times, th a medication error if the Lasix on bingo wouldn't be given a On 6/17/2015 at 9:2 conducted with the The DON stated in medication time, the the doctor and required could do this to acconeeds. The DON stated interviewed and the change for her Lasi On 6/18/2015 at 8:0 conducted with Res stated she liked to p right games. She w game days though, Lasix and that mad She liked to put it o have to disturb anyo On 6/18/2015 at 9:0 expected her nurse resident's choice for	ge 1 was the Lasix." She stated :30 AM that day to give the yould not be able to give the at all that day, and bingo didn't 00 AM. When the nurse was ever had any choice about he nurse stated it would create if she got a time change for days, because then the pill t the same time each day. 23 AM, an interview was Director of Nursing (DON). order to change a resident's e facility would just have to call test a time change. They commodate the resident's stated that resident #104 was e facility had gotten a time ix, to be given at 11:00 AM. 03 AM, an interview was sident #104. The resident olay bingo and the price is vasn't always able to make the because she had to take her e her go to the bathroom a lot. ff until 11:00 AM, so she didn't one during the games. 07 AM, the DON stated she is to notify the doctor of the r medication time, and see if amend the medication time the	F2	242	at time requested by resident. to be administered at 11AM daresident request. Physician or obtained by licensed nurse on A resident choice questionnair completed with 100% of all ale oriented residents to include re 104 regarding preferences in of Social Workers. The Minimum (MDS) Nurses immediately ad identified areas of concerns for resident choice questionnaire the resident care plan and care reflect the residents ¿ preferen 16, 2015. The Activities Direct the federal resident rights with oriented residents and a copy federal resident ¿s rights was g residents completed on July 7, copy of the federal resident ¿s sent to the responsible party b Administrator on July 7, 2015, residents. A 100% in-service was initiated by the Social Worker with all fa to include Nurse # 2, all Certifit Assistants (CNAs), all license dietary staff, therapy staff, hou staff, maintenance staff, activiti bookkeeping, receptionist and workers staff regarding resider and right to make decisions, to making choices regarding takin medication at a later time. All staff will be in-serviced by the development coordinator (SDC orientation regarding residents right to make decisions, to include choices regarding taking medi	aily per der 06-16-15. e was ert and esident # care by the Data Set dressed all om the by updating e guide to ce by July tor reviewed all alert and of the given to the , 2015. A rights was y the for all other d on 6/17/15 acility staff ed Nursing nurses, sekeeping ties, payroll, social nts rights o include ng newly hired staff C) during a rights and ude making	

Event ID: 00ZC11

Facility ID: 923414

If continuation sheet Page 2 of 10

		AND HUMAN SERVICES				FORM	07/17/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	· · ·	E SURVEY PLETED
		345266	B. WING	;		06/*	18/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
ROANO	KE LANDING NURSIN	G AND REHABILITATION CEN	TER		084 US 64 EAST LYMOUTH, NC 27962		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 242	Continued From pa	ge 2	F	242	later time. When a resident is admitted to the the resident or responsible party v informed by the Social Worker of right to make choices regarding a schedules, and health care consist with his or her interests, assessme and plan of care; to include choose take medication at a later time and choice questionnaire will also be presented to the resident and or responsible party regarding prefective care. The MDS nurses will immediate update the resident preferences of resident care guide and resident of plan. If during the facility stay the indicates a change in preferences include taking medications at a di time the residents care plan and of guide will be updated immediately MDS Nurse and or the licensed in contact the physician to obtain and for changing time of administration resident <i>c</i> sidents to include resident 104 by the MDS Nurses weekly x then monthly x 2 months to ensur- residents preferences are being h and for any changes in preference include time of medication admini- utilizing a QI Residents <i>i</i> Right to Tool. The MDS nurses will immediate address any identified areas of co and update the resident care plan resident care guide for any change contact the physician for order ch as needed. Resident care observi-	will be their ctivities, stent ents, sing to d a rences in diately on the care resident care resident care to fferent care by the urse will order n per be d lent # 8 weeks e ionored es to stration Choose diately oncern and es or anges	

Event ID: 00ZC11

Facility ID: 923414

If continuation sheet Page 3 of 10

		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		345266	B. WING		06/	18/2015
AME OF F	PROVIDER OR SUPPLIER	·		TREET ADDRESS, CITY, STATE, ZIP C 084 US 64 EAST	ODE	
OANOK	E LANDING NURSIN	IG AND REHABILITATION CENT	FR I	PLYMOUTH, NC 27962		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETI DATE
F 242 F 278 SS=D	The assessment m resident's status. A registered nurse		F 242	will be completed with 10% nurses and CNAs on all shift nights and weekends to obse nurses and CNAs to ensure preferences are being honor resident # 104 utilizing a Re Audit Tool 3x per week x 4 v x 4 weeks, then monthly x 2 MDS nurses, SDC, Resider Coordinator (RCC), and Qu (QI) Nurse. The Administrat of Nursing (DON) will review resident choice questionnai tool and the resident care a weekly x 8 weeks then mon months for completion and concerns were addressed. The DON will compile the re Residents ¿ Right to Choose Resident Care Audit Tool ar the Quality Improvement C monthly x 4 months. I dentit trends will determine the ne action and/or change in free required monitoring.	fts to include serve license e resident ored to include esident Care weeks, weekly 2 months by at Care ality Insurance for or Director v and initial the res QI audit udit tools thly x 2 to ensure all esults of the QI e Tool and the ad present to Committee fication of ed for further	7/16/15
	participation of hea	Ith professionals. must sign and certify that the				

If continuation sheet Page 4 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE CONSTRUC	TION	OMB NO. (X3) DATE	E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		COM	PLETED
		<b>345266</b> B.				06/*	18/2015
NAME OF I	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CO	DE	
ROANOP	KE LANDING NURSIN	G AND REHABILITATION CENTE	R	1084 US 64 EA PLYMOUTH,	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORF H CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 278	Continued From pa	ae 4	F 2	78			
	Each individual who	o completes a portion of the sign and certify the accuracy of					
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each as willfully and knowin to certify a material resident assessme	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each					
	Clinical disagreeme material and false s	ent does not constitute a statement.					
	by: Based on record re facility failed to acc (Minimum Data Set #49, and #78). Findings included: 1. Resident #49 ha on 12/18/2014 and 4/17/2015. Diagnos and the resident als The dietary care pla indicated the reside 1. Diabetes Mellit of hyper/hypoglyce non-compliance wit regimen. Intervention times, portion sizes allowed within dieta	NT is not met as evidenced eview and staff interview, the urately code the MDS t) for 3 of 22 residents (#13, d been admitted to the facility had been discharged on ses included Diabetes Mellitus so had a heel ulcer. an initiated on 12/22/2014 ent had the following problems: us: Potential for complications mia: Resident has history of th diet and /or treatment ons included: Discuss meal s, dietary restrictions, snacks ary rotation, importance and nce with nutritional regimen		assessme #78 were modificati and M so reflect the MDS Coc A 100% a assessme resident # conducted staff nurs Nurse Co July 16, 2 minimum residents identified,	mum Data Set (MD) ents for resident #13 reviewed and prope- ions were made to set that the coding wou e residents; condition ordinator by 6/18/15, audit of the last com- ent for all residents # 13, #49, and #78 v d by an MDS trained onsultant, to be com- 2015, to ensure cod data set accurately . For all areas of con- , a modification or sin of prior assessment	3, #49, and er sections E, H, uld accurately on by the pleted MDS to include will be d licensed and Facility npleted by ling of the reflects the ncern ignificant	

Facility ID: 923414

If continuation sheet Page 5 of 10

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· /	E SURVEY PLETED
ND PLAN (	JF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING		COM	PLETED
		345266	B. WING		06/	18/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ROANOI	E LANDING NURSIN	G AND REHABILITATION CENTE	RI	1084 US 64 EAST PLYMOUTH, NC 27962		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	Continued From pa	ae 5	F 278			
F 278	incorporate as man compatible with die 2. State of nourisit therapeutic diet, ele obesity, presence of included: will adher therapeutic/suppler The Quality Improvindicated the staff r food out at times. T the need for proper and diabetes mana understanding of the behavior was noted The Dietary Supple 3/11/2015 included sent outside of the The Quarterly/90 da 3/14/2015 indicated intact and indicated rejection of evaluat The Quality Improvindicated the staff r food from outside a educated on the ne wound healing and resident voiced und change in behavior The Quarterly MDS indicated the reside evaluation or care of The Behavior Program	n residents likes and dislikes; y likes as possible that are tary restrictions. ment related to: Being on a evated needs secondary to of pressure ulcer. Goal e to prescribed nental diet thru next review. ement note dated 2/25/2015 eported the resident ordered he resident was educated on nutrition to aid wound healing gement. The resident voiced e teaching. No change in l. mental Assessment dated a comment that the resident facility for food at times. ay MDS assessment dated the resident was cognitively the resident exhibited ion or care daily. ement note dated 3/25/2015 eported the resident ordered tt times. The resident was ed for proper nutrition to aid diabetes management. The lerstanding of the teaching. No was noted. a assessment dated 4/01/2015 ent was cognitively intact and ent exhibited rejection of daily. ress Note dated 4/09/2015 reported resident ordered take	F 278	(Quarterly/Comprehensive) will be completed by the facility MDS Coo and facility MDS Nurse by July 16 The MDS Nurses, Social Worker, Manager and Activities Director w re-in-serviced on proper coding of assessments per the Resident Assessment Instrument (RAI) Ma MDS Consultant to be completed 16, 2015. The MDS Nurses were in-serviced on the use of the Poin Care online RAI resource manual ensure accuracy in coding by MDS Consultant to be completed by Ju 2015. Teleconference on MDS co will be viewed by the Care Plan Te include MDS Nurse Coordinator, I Nurse, SW, DM, and AD by 7/16/ <sup>7</sup> When coding the MDS assessme MDS Nurse and Care Plan Team follow the instructions for proper of found in the Resident Assessmen Instrument (RAI) Manual and ensi- the assessment accurately reflect resident¿s current condition. An a 25% of completed Minimum Data (MDS) assessments will be condu- weekly x 4 weeks, then bi-weekly weeks, then 10% monthly x 2 mod MDS trained licensed staff nurse, Consultant or Facility Consultant of MDS Audit Tool to ensure complia accuracy utilizing a MDS audit Too MDS nurses will not be auditing th assessments. All identified areas concern will be addressed immed	ordinator , 2015. Dietary ill be MDS nual by by July also t Click to S ly 16, mpletion eam to MDS 15. nt the will coding t ure that s the judit of Set ucted for 4 nths by MDS using an ince and ol. The heir own of	

Facility ID: 923414

If continuation sheet Page 6 of 10

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED	
	345266		B. WING _			18/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
ROANO	KE LANDING NURSIN	G AND REHABILITATION CENTE	R	1084 US 64 EAST PLYMOUTH, NC 27962			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 278	with the ordered the	ge 6 erapeutic diet, did not follow endations and ordered food	F 27	'8 coding error and by the MDS modification or significant cor			
	this had been code have been coded a the resident was all about his condition	facility. The nurse then stated d incorrectly. It should not s rejection of care because ert and had received education and this was a choice the		<ul> <li>MDS. The Administrator will r initial the MDS Audit Tool wee weeks, then bi-weekly x 4 we monthly x 2 months.</li> <li>The results of the MDS Audit compiled by the Administrator presented to the Quality Impr Committee monthly x 4 month</li> </ul>	kly x 4 eks then Tool will be and ovement ns.		
	resident had made. #2. Resident #13 was admitted to the facility on 10/1/2005, with diagnoses to include traumatic brain injury, stoke and hemiplegia. Resident #13's quarterly Minimum Data Set (MDS) assessment dated 2/17/2015, indicated she was cognitively intact, and occasionally incontinent, which meant 7 or fewer episodes of incontinence on the prior 7 day look back period. Resident #13's quarterly MDS assessment dated 5/11/2015, indicated she was cognitively intact, and always incontinent. On 6/17/2015 at 11:55 AM, an interview was conducted with the nursing assistant (NA #1). NA #1 stated Residents #13's toileting had gotten more incontinent during the night, but during the day she was usually dry. At 12:00 PM on 6/17/2015, the resident stated she got up during the day to use the commode, but she cleant through the night and was not aware		Identification of trends will de need for further action and/or frequency of required monitor	change in			
	but she slept throug of needing to void r An interview was co (Nurse #1), on 6/17 stated resident #13 during the day, dep feeling. She was m had been this way f see a significant ch On 6/17/2015 at 2:3	gh the night and was not aware					

If continuation sheet Page 7 of 10

		AND HUMAN SERVICES			FORM	): 07/17/201 // APPROVEI ). 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		345266	B. WING		06	/18/2015
	ROVIDER OR SUPPLIER	G AND REHABILITATION CENTE	-R	STREET ADDRESS, CITY, STATE, Z 1084 US 64 EAST PLYMOUTH, NC 27962		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	documentation, and incontinence section The MDS nurse stat when she needed t not get up at night. always incontinent should have been of	the nurse's notes, the NA's d spoke to the staff to code the n of the MDS assessment. ated the resident could tell you o void during the day, but did The MDS nurse stated the coding was an error and it coded frequently incontinent, e at least one continent	F 278	3		
	8/6/14. Diagnoses i pelvic region and d ordered and started The significant char	nge Minimum Data Set (MDS) ted Resident #78 was always				
	Review of nurses' r	notes from 5/21/15 - 5/28/15 ntries indicating Resident #78				
		dated 5/28/15 indicated always continent of urine.				
		PM, an interview with a family daily revealed the resident nent.				
	Nurse #1 revealed incorrectly coded as	PM, an interview with MDS that Resident #78 was s always continent and that een coded as always				
F 371	483.35(i) FOOD PF	ROCURE,	F 37 <sup>-</sup>	1		7/16/15

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		OM	INTED: 07/17/2015 FORM APPROVED IB NO. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (	X3) DATE SURVEY COMPLETED
		345266	B. WING		06/18/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ROANO	E LANDING NURSIN	G AND REHABILITATION CENTE	R	1084 US 64 EAST	
			1	PLYMOUTH, NC 27962	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 371 SS=D	Continued From pa	ge 8 /SERVE - SANITARY	F 371		
	considered satisfact authorities; and	om sources approved or tory by Federal, State or local distribute and serve food litions			
	by: Based on observat facility failed to prove eat foods and bare were observed to p hands while assistin & #90) during 1 of 2 findings included: On 6/5/15 at 11:48 delivered and perfor for Resident # 73. the bread from a bac hand. During an interview AM she stated she handled the bread with During an interview Dietary Manager st not be touched with During an interview Director of Nursing touch ready to eat f	on 6/18/15 at 9:15 AM the ated ready to eat foods should		NA # 2 and NA # 3 were in-serviced the need to have a barrier, such as a wrap, between ready to serve foods, as bread, and bare hands when serv meals to the resident with return demonstration given by Staff Development Coordinator (SDC) completed by July 7, 2015. 100% in-service to be completed for Licensed Nurses, Certified Nursing Assistants (CNAs) and Department Managers to include NA #2 and NA # the SDC and Administrator by July 1 2015, regarding providing a barrier, as deli wraps, between ready to eat such as bread, and bare hands when serving residents meals with return demonstration given. All newly hired licensed nursing staff, CNAs and Department Managers will be in-serv by the SDC during orientation regard providing a barrier, such as deli wrap between ready to eat foods, such as bread, and bare hands when serving	a deli , such /ing #3 by 6, such foods, n viced ting ps,

Facility ID: 923414

If continuation sheet Page 9 of 10

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				NG		
	345266		B. WING _	STREET ADDRESS, CITY, STATE, ZIP COD	-	18/2015
	PROVIDER OR SUPPLIER	IG AND REHABILITATION CENTE	R	1084 US 64 EAST PLYMOUTH, NC 27962	Ξ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 371	She was observed with her bare hand bag. During an interview stated she did not in the bread with her During an interview Dietary Manager st not be touched with During an interview Director of Nursing	of the tray for Resident # 90. to touch the resident ' s bread s while removing it from the on 6/5/15 at 12:05 PM NA #3 realize she should not touch bare hands. on 6/18/15 at 9:15 AM the tated ready to eat foods should	F 37	residents meals with return demonstration. When serving ready to eat foo bread, licensed nursing staff, O Department Managers will ensibarrier, such as a deli wrap, is the ready to eat food, such as their bare hands. Meal observa will be conducted by SDC, Qua Improvement (QI) Nurse One, Two, MDS Coordinator and MI using a Food Preparation Audi breakfast, lunch and dinner da x 4 weeks then weekly x 4 wee monthly x 2 months to ensure provided a barrier between rea foods and bare hands. The Ad will review the Food Preparatic weekly x 8 weeks then monthly months and initial. The results of the Food Preparation Audi be compiled by the Ad and presented to the Quality Ir Committee monthly x 4 month Identification of trends will deteneed for further action and/or of frequency of required monitorier	CNAs, and ure that a between bread, and ation audits ality QI Nurse DS Nurse t Tool for ily 5 x week eks then staff ady to eat ministrator on Audit Tool y x 2 ration Audit Iministrator nprovement s. ermine the change in	

Facility ID: 923414

If continuation sheet Page 10 of 10